



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

August 12, 2004

Honorable Beverly S. Hammerstrom
State Senator, 17th District
S-8 Capital Building
Lansing, Michigan 48909

Dear Senator Hammerstrom:

Several months ago you wrote to Director Olszewski requesting that the department provide an analysis of a particular funding option for public mental health services. Specifically, you were interested in an examination of financing opportunities associated with a Section 1115 Medicaid waiver for mental health care.

I apologize for the delay in completing this analysis. In exploring the waiver option, I found it necessary to clarify certain aspects of current mental health funding arrangements, in order to provide a proper context for discussion of the 1115 alternative.

I hope that I have adequately addressed the topic in my analysis (enclosed). Please let me know if you have further questions or would like any additional clarification of issues raised in the paper.

Sincerely,

A handwritten signature in cursive script that reads "Patrick Barrie".

Patrick Barrie, Deputy Director
Mental Health and Substance Abuse Services Administration

Cc: Janet Olszewski, Director, Michigan Department of Community Health
C. Patrick Babcock, Michigan Mental Health Commission
Waltraud Prechter, Michigan Mental Health Commission

PUBLIC MENTAL HEALTH FINANCING CONSIDERATIONS

There has been extensive discussion within the Mental Health Commission regarding the use of Medicaid reimbursement to fund public mental health services in Michigan. Over the last two decades, Michigan (similar to other states) has made increasing use of certain optional Medicaid coverages and reimbursements to underwrite a wide range of community-based treatment services and rehabilitative programs. In an earlier presentation to the Commission on this subject, I displayed a timeline that provided a graphical representation of the expansion of Medicaid mental health services throughout the past 25 years. Another speaker (Judith Taylor), at the same Commission seminar, described the significant role that Medicaid reimbursement assumed within Michigan's public mental health system over time, enlarging the resource base supporting community services and forestalling deep service retrenchments during periodic economic recessions (the so-called "counter-cyclical" effect of Medicaid).

The gradual expansion of Medicaid services and reimbursement within the public mental health system was generally regarded as progressive public policy, especially as deinstitutionalization accelerated during the 1980s. Many individuals with serious mental illness exiting state facilities had significant residual disabilities as a result of their illnesses. These individuals qualified for income support through the supplemental security income (SSI) program and hence were also categorically eligible for Medicaid.

Medicaid is a complex program, but its basic structure offers states great flexibility in meeting various health care objectives. If a state elects to participate in the Medicaid program, it must extend eligibility to specified groups and it must cover certain required (mandatory) services. But states also have the option of extending Medicaid eligibility to other categorical groups and to offer additional (optional) services beyond basic or mandatory benefits. The state can claim federal matching funds (at the state's federal medical assistance percentage or FMAP) for the provision of these services to Medicaid beneficiaries. In the 1980s and early 1990s, Michigan adopted several optional services that specifically addressed the treatment, support and rehabilitation needs of Medicaid beneficiaries with serious mental illnesses. Since Medicaid is jointly financed by federal and state governments, community mental health services programs (CMHSPs) agreed to utilize a portion of their state general fund allocations as the required "state match" necessary to claim or draw down federal reimbursement for the provision of these newly adopted Medicaid services.

Standard or "default" Medicaid contracting and payment arrangements (specifications in federal law and/or administrative rules) have historically posed obstacles to organizing Medicaid service provision and reimbursement around sub-state entities such as CMHSPs. Throughout the 1980s and early 1990s - as the optional mental health related services were added to the state Medicaid plan - Michigan used a number of strategies to overcome these obstacles, and to channel Medicaid service provision and payments through the CMHSP system. These strategies permitted the local entities to maintain unified and consolidated system management over the services and resources (Medicaid and general fund) that supported seriously mentally ill and developmentally disabled individuals in the community. However, these stratagems became increasingly more intricate and difficult to preserve over time. At least one rationale for the transition to Medicaid managed mental health care (the 1915(b) specialty services waiver) in 1998 was that this approach (designating CMHSPs as "Prepaid Health Plans") provided the most workable method for reconciling Medicaid regulations with the responsibilities envisioned in state law for CMHSPs.

Despite the discussions and presentations on this topic within the Commission, there seemingly remains some confusion regarding the role of Medicaid in financing public mental health services in Michigan. This confusion lingers, in part, because the discussions have not clearly differentiated the financial impact of Medicaid in supporting services for *persons with developmental disabilities* from Medicaid's role in paying for care of persons with *serious mental illness and serious emotional disturbances*. The often cited estimate that Medicaid reimbursement comprises nearly 70% of the funding for CMHSPs is somewhat misleading, insofar as this estimation lumps together Medicaid funding for services to the developmentally disabled with Medicaid expenditures on behalf of persons with serious mental and emotional illnesses. Nearly all individuals with a developmental disability served through the public mental health system are eligible for Medicaid and hence Medicaid reimbursement is the preeminent funding source for this population. However, Medicaid eligibility is more variable for persons with serious mental illness, and hence Medicaid reimbursement for services to this population, while still very significant, is less dominant in the total public financing picture. A recent review of state mental health funding suggests that Medicaid reimbursement comprises approximately 47% of the public funds spent on mental illness within the Michigan public mental health system, while state general funds and other non-Medicaid revenues account for roughly 53% of total expenditures.¹

Although Medicaid revenue is not as dominant a funding force in the mental illness side of the public system as it is for developmental disability services, it is nonetheless true that enhancements in mental health funding in recent years have invariably involved incremental growth to Medicaid payments, not increases to general fund appropriations. Indeed, there have been modest erosions (Executive Order in December 2002) and unavoidable but painful diversions of mental health general fund appropriation amounts over the last several budget cycles, due primarily to the lingering recession and continuing state revenue shortfalls. For example, in last year's appropriation cycle, funds were moved from the mental health general fund appropriation line to provide financial support (state match) for the Adult Benefit Waiver, a means-tested, eligibility-driven, defined benefit health insurance program (which has a mental health benefit component) for childless adults. Given the state's current revenue situation and discussions regarding enduring "structural" revenue problems, one might predict that public mental health funding will continue to gravitate toward financial arrangements (Medicaid, Adult Benefit Waiver, MiChild, etc.) that offer some degree (often significant) of federal financial participation and cost sharing.

Many observers have noted unfortunate consequences in the shift of public mental health financing toward Medicaid and other jointly financed (federal/state), means-tested, defined benefit public insurance programs. This shift has presumably reduced public funding available to serve low-income uninsured (or underinsured) individuals with serious disorders or less severe conditions that nonetheless involve significant symptomatic suffering and impairments. The distinction within the public system between those eligible for Medicaid (or for other joint federal/state insurance arrangements) and those lacking such coverage is heightened by the fact that Medicaid is an individual entitlement program with a defined set of benefits (the other joint federal/state insurance programs also have an eligibility and defined benefit structure) while state-supported mental health programs - financed through general fund appropriations

¹ Not included in this analysis is the considerable amount of Medicaid spending on psychotropic medications, since this is currently paid out of the Medical Services Administration appropriation, not the CMHSP Medicaid Mental Health appropriation line.

and governed by Mental Health Code provisions - are directed toward priority groups and have more variable and discretionary service obligations.

Reacting to this situation, and perplexed by the complexity of existing public funding transactions, some have suggested that eliminating the Medicaid specialty managed care program and the 1915(b) waiver would somehow resolve these access and service inequities. Proponents of this view assume that changes in Medicaid arrangements would significantly increase general funds available for community mental health care. However, given that Medicaid is a less dominant revenue source for public mental illness services, different arrangements for Medicaid mental health benefits would likely have only a small impact on the amount of unrestricted general fund dollars in the public system, and such changes would surely reduce the *total pool* of available public funds for community-based care (due to decreased federal matching payments).² Moreover, discontinuation of the waiver program would also eliminate Medicaid financial support for various “alternative” services (such as peer-operated services and housing assistance) that are permissible support options under current waiver terms and conditions.

In short, access and service problems with the public system are not simply a matter of too much Medicaid funding or too few general fund dollars. Indeed, the frequently cited Senate Fiscal Agency synopsis of recent trends in mental health funding indicated that **both** Medicaid payments and general fund allocations for mental health care have been tightly constrained over the past several years. The friction within the public system is between the legally enforceable *individual entitlement* to coverage that Medicaid affords, and the *non-entitlement, discretionary nature* of general fund supported mental health programs, where allocations may not necessarily match demand or need. If Medicaid eligibility rises during the year, budgetary adjustments are made to address the added numbers of beneficiaries and the anticipated additional costs of care. However, in a “discretionary” general fund program, the appropriated dollar amount, rather than nominal eligibility standards or the need for care, ultimately determine how many individuals the program serves and which services individuals receive.

Standing somewhere between the entitlement (Medicaid) and the discretionary (general fund) pathways to publicly supported mental health care, are other programs such as MiChild³ (Michigan’s version of the State Children’s Health Insurance Program or SCHIP) and the Adult Benefit Waiver (ABW)⁴, both of which have a mental health coverage as a component of program benefits. Like Medicaid, these arrangements are federal/state matching programs (indeed, for Michigan, the federal matching rate for these programs is more generous than the FMAP rate for Medicaid). However, unlike Medicaid, federal matching payments are capped at a specific amount each year (i.e., they are “*closed-ended*” matching programs, and operate more like a block grant). Under these types of capped federal allotment arrangements, states may limit the enrollment of eligible individuals into the program, in order to stay within their capped quota of federal matching payments. Individuals who qualify for the program before an enrollment cap is reached will be covered for certain defined benefits. Other similarly situated individuals who apply after an enrollment cap is reached may be denied coverage. Federal payments (and state matching funds) are not adjusted in response to changes in potential eligibles or increases in service utilization. Payments related to these “closed-ended”

² At the FY 05 FMAP rate of 56.7%, for every \$1 that the state spends, it receives \$1.30 in federal matching funds.

³ MiChild is authorized under Title XXI (State Children’s Health Insurance Program) of the Social Security Act

⁴ The Adult Benefit Waiver (ABW) is a so-called HIFA (Health Insurance Flexibility and Accountability) waiver, authorized pursuant to Section 1115 of the Social Security Act, financed (in part) with unexpended SCHIP funds.

federal/state matching programs now comprise about 6% of the public funds spent on mental illness within the Michigan public mental health system.

THE FUNDING FRAMEWORK OF PUBLIC MENTAL HEALTH: PAST, PRESENT, AND FUTURE

Thirty years ago the most pressing problem in the public mental health system was over-utilization of restrictive state institutions and the lack of a viable community service and support infrastructure to provide care outside these facilities. The modern “formal” public mental health system was developed to address these issues, and the funding framework employed to foster change involved incentives for counties to move persons with serious mental illnesses into the community and to create comprehensive local service delivery systems to meet the needs of adults with serious mental illnesses and children with serious emotional disturbances. The initial funding mechanism was relatively simple in structure and straightforward in its incentive arrangements: the state and the counties shared the cost of public mental health care on a 90% (state) - 10% (county) basis, and counties (through their community mental health programs) retained the state share of public mental health funding when they reduced their utilization of state institutions. These retained state funds could then be invested to expand local service delivery capacity.

However, this initial funding framework, in its original form and magnitude, was insufficient to support the full cost of community-based care for persons with serious mental illness, and to finance the growth of comprehensive local service delivery systems. To remedy this insufficiency, the funding framework was gradually extended to include Medicaid coverages and federal reimbursement. The introduction and expansion of Medicaid reimbursement made the funding framework for community care more robust, but it also made it much more complicated, and more prone to budgetary adjustments that undermined the initial state/county collaboration on mental health care.

Over time, the funding framework for public mental health has become even more intricate, as closed-ended federal/state matching programs (such as MiChild and ABW) were added to the mix, necessitating further diversion of mental health general fund dollars as the required state match for these programs. As general fund allocations have become more constrained, CMHSPs have less discretionary funds available to address state and locally defined needs and priorities.

We now live in a post-deinstitutionalization era. The number of state hospital beds has dropped precipitously, and most individuals with serious mental illness served by the public mental health system are now treated through locally administered delivery systems. The problems of thirty years ago – too many individuals in restrictive institutions and limited local service capacity – have largely receded, replaced by distinctive contemporary dilemmas. Today, the most pressing problems facing public mental health systems nationwide involve dwindling general fund resources, rising demand for services, and increasing numbers of individuals with significant mental health needs popping up in other public systems, designed to address different social (child welfare), legal (law enforcement, courts, corrections), and instructional (education) concerns.

Some commentators have speculated that the decline in general fund support for public mental health services is an unintended side effect of the transition from institutional to community-based care. In the 1980s and early 1990s, when there were more state psychiatric facilities,

unavoidable economic increases in the facilities (salaries, wages, fringe benefits, utilities, etc.) provided a crude form of indexing and a rationale for some adjustments in general fund appropriations for mental health care. As CMHSPs reduced facility utilization, some of this additional state funding moved to the community as “trade-off” dollars. With the reduction in facility census and the closure of state facilities, the need for funding adjustments (related to unavoidable economics, cost increases and/or service demands) became more opaque, and indexing mechanisms (pegged to facility cost increases) previously employed were largely abandoned. Hence, consideration of unavoidable economic increases related to the general fund appropriation for mental health virtually ceased, even prior to the economic downturn that began in 2001. Even when state revenues were robust and growing, the general fund appropriation for Community Mental Health was not materially adjusted to reflect economics or changing service demand/utilization characteristics in the community.

Even as the state economy gradually rebounds, significant increases in state general fund allocation for public mental health care are unlikely. Many commentators expect sustained fiscal distress for states over a number of years. Robert Behn and Elizabeth Keating (Taubman Center for State and Local Governments at Harvard University) have written that:

“...state policymakers should prepare themselves to deal with tough fiscal times for the rest of the decade and (depending upon what actions governments take) maybe longer. *The fiscal trends are clear. The existing built-in financial demands of the states’ current responsibilities are growing more rapidly than are revenues.*”⁵

Deficiencies in private insurance coverage for mental health services (including coverage limitations and low reimbursement rates for private providers), the growing number of uninsured individuals, and increased public awareness of effective treatments for mental illnesses (particularly the new, improved and relatively more expensive, pharmaceutical treatments) have all played a role in the rising demand for publicly supported mental health care, demand that the system has been unable to satisfactorily address. These demand pressures, attributable to a variety of factors that are outside the control of the public system, nonetheless contribute to the perception of a crisis in publicly supported mental health care.

Finally, the pervasiveness of significant mental health problems among persons served through other public systems (welfare, child protection, juvenile justice, law enforcement, courts, corrections, education) has been well established and documented across the nation. Whether this represents a simple failure of the public mental health system, novel or unanticipated situations, the collective effect of other social policies and societal changes, the cumulative impact of social disadvantages⁶ (e.g., poverty, low educational attainment, etc.) experienced by persons with significant mental health problems, or some combination of these factors is still subject to debate. While the causes of this phenomenon (increasing numbers of persons with significant mental health needs among the clientele of other public agencies) may be in dispute, one thing is certain: other agencies and entities are frequently ill-equipped to deal with such mental health needs, and these settings do not often represent adequate or appropriate treatment venues for such conditions.

⁵ Facing the Fiscal Crisis in State Governments: National Problems; National Responsibilities; Behn, R. & Keating E. (2004)

⁶ “The Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness”; Draine, J., Salzer, M. et al, *Psychiatric Services* (May 2002)

The Mental Health Commission, quite properly, is attempting to fashion a vision and plan for the public mental health system that is (to some extent) independent of the constraints and limitations inherent in the current funding arrangements that support the public system. To proceed otherwise (to constrict the vision and plan to fit the contours of existing funding sources) would unnecessarily limit the perspective, aspirations and creativity of the Commission. However, in contemplating recommendations to address immediate concerns and promote incremental steps towards comprehensive system reform, the Commission will encounter three fundamental questions⁷ relating to the funding framework for publicly supported mental health care:

1. How can DCH - the State Mental Health Authority (SMHA) - and the CMHSPs organize and manage the “formal” public mental health system in a manner consistent with the state vision, plans, policies, priorities, needs and preferences, when the system is supported by multiple funding sources that confer differential access rights and service obligations, and which have variable potential for funding adjustments when demand or need for mental health care changes?
2. What approaches, mechanisms and/or arrangements can the state employ to better synchronize the efforts of the formal public mental health system (both state and local levels) with mental health related activities *performed* (either by necessity or in response to separate requirements) by other state agencies (OSAs) - child welfare, juvenile justice, corrections, education – and entities (e.g., Medicaid health plans, Federally Qualified Health Centers [FQHCs], etc.), and *funded* by federal and state resources outside the jurisdiction of the formal public mental health system?
3. Since state efforts to improve the *public* mental health system are inextricably linked to the adequacy of mental health coverage in *private* employer-sponsored insurance (ESI) plans, how can the state work with employers to improve the availability, adequacy and affordability of mental health coverage within ESI plans?

In the next section, I will briefly review possible remedies to the problem posed in the first question above. Examining this matter, the major task appears to be altering the complexity and discrepancies inherent in current funding mechanisms, and devising more straightforward, transparent, flexible and equitable financing arrangements. Like all economic transactions, however, such adjustments imply various “trade-offs” that have to be carefully weighed and deliberated.

⁷ Beyond the three basic questions, I would suggest that four additional funding related questions merit Commission consideration:

4. Given the high rates of co-morbid medical conditions among persons with serious mental illness (SMI), what funding mechanisms or arrangements might be devised to encourage and incentivize closer *integration* between the public mental health system (responsible for specialized mental health treatment and supports) and general medical care systems (primary care providers, health plans, FQHCs, etc.)?
5. Since individuals with serious mental illness, and children with serious emotional disturbances, often need and qualify for other ancillary services and core benefits (e.g., income supports, food stamps, housing assistance, vocational rehabilitation, workforce development, supported education, etc.) provided by other state/federal agencies and resources, how do we better *align* public mental health care with access to these other programs and resources?
6. Given epidemiological studies on the prevalence of substance abuse disorders among those with serious mental illnesses, how can public funding be configured to underwrite integrated treatment for those with co-occurring disorders in the public mental health system?
7. What financing mechanisms can the state develop or enhance to promote prevention and early intervention programs for at-risk populations, particular children?

Extended consideration of the two remaining funding questions is beyond the scope of this analysis. I would note, however, that resolving the intricate issues associated with these other questions will be a challenge.

Fragmentation in the delivery and financing of mental health related services across the public system and other state agencies (OSAs) have long been recognized as a problem both in this state and in most other states across the nation. However, despite such recognition and extensive work on systems integration, there remain persistent and refractory obstacles to cross-system coordination. While some blame simple bureaucratic inertia for the slow pace of cross-system integration efforts, the real and more substantial obstacles are some rather intricate legal, regulatory, funding source and cost allocation constraints. These obstacles are certainly not insurmountable, but overcoming these barriers requires sustained interagency effort, specialized expertise, and a clear vision of expected outcomes. While many states have made significant progress in aspects of cross-system integration (and Michigan has had some accomplishments through the efforts of the Multi-Purpose Collaborative Bodies), no state has been entirely successful in these endeavors. This has led at least one state (New Mexico) to experiment with a more radical approach to cross-system collaboration.⁸

Likewise, efforts to improve the availability and adequacy of mental health coverage in private employer-sponsored insurance plans have had mixed success. Certainly, achieving parity is an important legal and symbolic milestone, both nationally and in this state. However, even when basic parity has been attained, employer-sponsored insurance benefits rarely include the types of mental health interventions (e.g., assertive community treatment) that are essential for the care and treatment of individuals with serious mental and emotional disorders.

In making these cautionary remarks, I am not suggesting that we deter or delay efforts to dramatically improve cross-system coordination or to expand mental health coverage in ESI plans. However, in deliberating recommendations regarding these aspects of the funding framework, the Commission should be cognizant of the difficulties associated with these matters, and identify steps that must be taken to successfully overcome these impediments.

WHAT CAN BE DONE?

States have long had an ambivalent attitude towards the Medicaid program. On one hand, Medicaid provides federal financial participation for health care programs and services that were often previously funded solely by state and local dollars. On the other hand, since Medicaid is an entitlement program, states have less budgetary control over Medicaid expenditures and must provide state match funds to secure the available federal financial contribution. As a program, Medicaid is “demand-driven” (enrollment and utilization) which makes it very different from “budget-driven” discretionary programs in which eligibility criteria and service use are constrained by the preset amount of funds appropriated for the program.

This ambivalent attitude has been apparent in the deliberations of the Mental Health Commission. While in some discussions Commissioners have expressed reservations regarding the growing prominence of Medicaid as a funding source for services to the mentally ill, at other moments Commissioners have tentatively endorsed new Medicaid maximization strategies, particularly those that apply to expanding children’s services. The dilemma associated with new

⁸ See the New Mexico Interagency Behavioral Health Purchasing Collaborative at: www.state.nm.us/hsd/bhdwg/

Medicaid maximization proposals is that such plans may require further diversion of scarce general funds to provide the required state match component.⁹

Regardless of one's personal opinion regarding Medicaid, there is no escaping the fact that Medicaid eligibility conveys an individual entitlement to a defined set of mental health benefits, while other sources of funding carry more variable and discretionary access and service conditions. While many find this situation (different funding arrangements confer diverse access rights and service obligations) distressing, there is no simple way to resolve these disparities.

In previous Commission deliberations, various ideas have been offered on how to mitigate this situation. One suggestion was a limited expansion of Medicaid eligibility using various special eligibility pathways available under current law for disabled individuals. However, use of such eligibility pathways would convey eligibility for all Medicaid benefits, not merely those related to specialized mental health treatments and supports. Hence, it is more difficult to predict the budgetary impact of the proposed special categorical expansions. Moreover, many individuals with serious mental illnesses or emotional disturbances would still not qualify, even under these special eligibility pathways.

Others have suggested - as an alternative to expanding Medicaid eligibility - that the Mental Health Code be amended to provide an individual, enforceable, right to treatment for all Michigan residents with a serious mental illness or emotional disturbance. While this approach dispenses with the need to expand Medicaid eligibility, it would necessitate a substantial increase in the general fund appropriation for mental health to underwrite the cost of such a provision.

Neither limited categorical Medicaid eligibility expansions nor state statutory change (to create an enforceable right to treatment within the Mental Health Code) seem feasible in the current fiscal climate. However, there may be another approach that could (arguably) make the system more equitable in access and service determinations, and might reduce operational and administrative transaction costs. This approach is by no means a panacea, and it has its own pitfalls and limitations. It entails moving even further in the direction of the "health plan" model for mental health care.¹⁰ With these caveats, I will sketch out the Section 1115 waiver option.

SECTION 1115 WAIVERS

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain portions of the federal Medicaid Act (Title XIX) for research and demonstration projects proposed by the states. Under an 1115 waiver, a state may be permitted to use federal Medicaid matching funds for populations and/or services that would otherwise not be permissible under the federal Medicaid statute. States have used the 1115 waiver authority to cover populations who otherwise could not qualify for Medicaid, and to provide a tailored benefit package (rather than full Medicaid benefits) to the targeted expansion group.

⁹ Medicaid is not the only program the state is looking at for revenue maximization possibilities. See the solicitation "Revenue Maximization Services for Michigan" (Bid No. 07114001225) on the Department of Management and Budget Web Site (<http://www.state.mi.us/dmb/apps/oop/itbBids.asp?itb=07114001225>)

¹⁰ "Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Systems"; Jeffrey Buck; *Psychiatric Services* (July 2003).

Long-standing federal policy requires that all Section 1115 waivers be “budget neutral”; that is, the 1115 waiver cannot cause federal spending to increase over what it would have been without the waiver. Budget neutrality is generally calculated over the entire five-year period of the demonstration waiver, not each individual year.

Given the requirement of budget neutrality, how can states finance Section 1115 waivers? A popular method in the past was to reinvest savings achieved from Medicaid managed care to finance expanded eligibility (under the 1115 waiver) for individuals who would not normally qualify for Medicaid. Also, to further control expenditures, enrollment of expansion populations has generally been capped at some level, benefit packages are more limited, and substantial cost-sharing requirements are imposed.

The use of projected managed care savings to finance Section 1115 waiver eligibility expansions have steadily faded. Most of the savings related to managed care have already been realized by states, and hence The Centers for Medicare and Medicaid Services (CMS) does not generally regard new waivers premised upon large managed care savings as credible proposals. Currently, the most common funding source used to finance coverage expansions under the 1115 authority is unspent State Children’s Health Insurance Program funds (up to the state’s SCHIP allotment).¹¹

There is, however, another potential source of funding for a Section 1115 waiver, one that figures prominently in the proposal described below.

A MENTAL HEALTH SECTION 1115 WAIVER

As noted previously (and repetitiously) in this analysis, the public mental health system is supported through multiple funding streams with disparate requirements. Reducing these disparities is key to diminishing system complexity, lessening inequities, and decreasing administrative burden.

Currently, an individual’s access to public mental health care - and the type, level and scope of services received - is mediated to some extent by whether the person is a Medicaid beneficiary, a MiChild enrollee, an Adult Benefit Waiver recipient, or a “priority population” designee, seeking general fund supported services (note: many of those covered through Medicaid, MiChild or the ABW *may also qualify* as a priority population designee under Mental Health Code definitions and provisions).

One possible way to reduce or diminish some funding-source induced distinctions would be through a Section 1115 *mental health waiver*. Under such a proposal, the existing 1915(b) Medicaid specialty services waiver would remain intact, with no changes for Medicaid beneficiaries and no alteration to current benefits and funding arrangements.¹² The state would, however, request approval - under a separate 1115 waiver - to extend limited Medicaid coverage to certain targeted expansion groups (adults with serious mental illness and children with serious emotional disturbances) who are currently categorically ineligible for Medicaid (or SCHIP). The concept of “condition-based” targeted expansion groups, with limited benefit coverage, parallels some existing special federal eligibility parameters, which afford eligibility and certain benefits to those with particular illnesses or diagnoses (e.g., tuberculosis).

¹¹ The General Accounting Office has criticized this use of unspent SCHIP funds. See GAO-04-166R (January 2004)

¹² Although the current 1915(b) Medicaid mental health waiver could be subsumed into an 1115 waiver, I have chosen (for certain technical and pragmatic reasons) not to recommend its inclusion in the 1115 proposal.

Under such an arrangement, adults and children (that meet certain income criterion) who are certified as seriously mentally ill or serious emotionally disturbed according to state Mental Health Code definitions, would be eligible for a defined set of Medicaid mental health benefits. It is likely that the waiver would have an enrollment cap (not everyone who met the eligibility criteria could be enrolled), and it is unclear at this point how severity of condition might be incorporated into eligibility considerations and an enrollment cap methodology. Cost-sharing requirements for covered benefits would correspond to the ability-to-pay provisions of the Mental Health Code.

To further consolidate and simplify administration requirements within the public mental health system, I would suggest that mental health coverage for MiChild enrollees and ABW recipients be folded into the 1115 waiver, and that the benefits for these enrollees/recipients be comparable to the mental health benefit package available to targeted expansion groups under the 1115 waiver.

Federal funds (budget neutrality) to finance the proposed Section 1115 mental health waiver could come from redirecting existing Medicaid Disproportionate Share Hospital (DSH) payments. Federal law permits state Medicaid programs – under certain criteria, conditions, and limitations – to make supplemental or additional payments to hospitals that serve large numbers of Medicaid beneficiaries and other low-income individuals. Federal funding for DSH payments does not flow to states on an open-ended basis; rather, specific amounts are allocated to states according to federal statute.

Michigan, similar to many other states, distributes a portion of its DSH allocation to state psychiatric hospitals.¹³ These funds are eventually returned to the state treasury and are used to address other health related expenditures (e.g., Medicaid inpatient and outpatient hospital expenditures charged to the Medical Services Administration appropriation). While legislation passed in 1997¹⁴ has constrained payment of DSH funds to state psychiatric facilities, Michigan still identifies roughly \$140 million of its DSH allotment as payments to state psychiatric facilities.

If federal DSH funds nominally paid to state psychiatric hospitals were redirected to provide federal funding for an 1115 mental health coverage expansion waiver, this would create a shortfall elsewhere in the Department of Community Health budget (presumably in the hospital line of the Medical Services Administration appropriation). This shortfall would have to be addressed and consideration given to the possible sources for replacement funds. It is possible, given the period needed to prepare and submit an 1115 waiver and the lengthy federal review process, that time itself could reduce the size of this problem (i.e., sustained economic recovery, lower unemployment, increased state revenues, and a decline in the size of the Medicaid caseload) before the state actually implemented the program. However, in light of this complication (and the uncertainty of its resolution) it seems fair to ask whether this approach – linking a proposed Section 1115 mental health waiver to the redirection of existing DSH funds - actually accomplishes anything. What are the tangible benefits of this approach?

¹³ Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals; GAO/HEHS-98-52 (1998)

¹⁴ Overview of Medicaid Provisions in the Balanced Budget Act of 1997; Andy Schneider, Center for Budget and Policy Priorities (1997)

In considering this question, I can identify five “potential” benefits to the public mental health system from an 1115 waiver. I leave it to the reader to decide whether these possible benefits outweigh the shortcomings and inconvenience of this approach.

1. An 1115 waiver could diminish (to some extent) access and service disparities inherent in the current multiple funding source situation. Medicaid beneficiaries would still enjoy an entitlement to service and the defined benefits of the 1915(b) waiver, but the targeted expansion populations (if enrolled) would now have an enforceable claim to a similar package of services and supports.
2. An 1115 waiver, incorporating recipients currently served under MiChild, ABW and general fund arrangements, and operating under terms and conditions that parallel current Medicaid requirements, would (arguably) reduce administrative complexity and improve the operational consistency.
3. If the payment for 1115 waiver enrollees were a capitated arrangement, CMHSPs would not be obligated (under my interpretation) to provide local match for the state/federal funds paid out in this manner (i.e., the payment is no longer being made on a “net-cost” basis). Hence, these now unencumbered local funds could be used to address locally determined mental health needs and priorities.
4. For those targeted expansion groups enrolled in the 1115 waiver, I am assuming that the state could claim manufacturer rebates on psychotropic drug expenditures for these enrollees (depending upon how a pharmacy benefit was structured in the 1115 waiver). Currently psychotropic medication costs for many of these individuals are paid for with general funds, without the manufacturer rebates available to Medicaid under federal law.
5. The state could request - as part of the 1115 waiver - an exemption from the so-called Institution for Mental Disease (IMD) exclusion, which prohibits the use of Medicaid funds (with some age-related exceptions) to pay for services in state adult psychiatric facilities. Such an exemption (if properly formulated) might permit CMHSPs to use federal funds as a reimbursement source for care in state facilities.

There likely are other advantages that I have not considered in this brief overview of the 1115 option. More importantly, there are probably many problems and pitfalls with such an approach that I have not clearly delineated or discussed. Obviously, there remains the issue of those who qualify for enrollment under an 1115 waiver, but are denied due to an eligibility cap. How are the service needs of such individuals to be met? Would there be enough general funds available to provide necessary care for these individuals and to address other Code requirements (e.g. jail diversion)? Some of these difficulties might be partially ameliorated if CMS would grant the state approval to use savings generated in a particular year under the 1915(b) waiver for the purpose of expanding targeted eligibility enrollment under the 1115 waiver in the following year. All of these issues and questions, however, require much more careful consideration and deliberation.

There are many who dislike section 1115 waivers; either they reject them on principle or else they object to the way such waiver authority has been used in particular instances. While most Federal programs have tightly constrained legislative parameters, section 1115 gives the Secretary of Health and Human Services extremely broad authority to modify significant aspects of certain programs (e.g., Medicaid) without prior Congressional review or approval and with limited public involvement. Changing federal policies and priorities alter the types of 1115 waivers approved by the Secretary, and the financial arrangements negotiated in these waivers can have a substantial impact on states and beneficiaries, unless a state is skillful in bargaining with CMS.

Presently, many are concerned about the direction of federal waiver policy, fearing that the structure and conditions of certain approved waivers are a slippery slope, moving Medicaid from an entitlement program toward a block grant arrangement (which poses significant risks for states). However, many federal officials and members of Congress have been equally critical of the states, citing several controversial “creative” financing mechanisms used by states to draw down more federal funds without the state actually committing any additional state matching funds.¹⁵ While various financing strategies have initially been legal and permissible, Congress has repeatedly responded to the growth of the creative financing mechanisms by enacting legislation that either restricts or limits the use of these approaches. While Michigan, similar to other states, has been criticized for past use of certain special financing arrangements, it is important to note that the public mental health system never relied heavily on such mechanisms¹⁶ and entirely eliminated use of such arrangements with the onset of the Medicaid specialty managed care program in October 1998.¹⁷

AN EPILOGUE

If times were different, if the fiscal circumstances of federal, state and local governments were better, if there was greater trust and less animosity between various levels and units of government, I would have proposed a much more ambitious financing strategy for public mental health services. If the federal government wasn’t concerned about inappropriate state financing schemes, if states weren’t worried about federal caps and “clawbacks”, if local governments weren’t lamenting the dark side of devolution, I would have suggested a new deal on public mental health financing.

The current complexity of public mental health funding reflects an ongoing tug of war between levels of government (and the private sector) over who should bear what costs related to the care, treatment and support of adults with serious mental illnesses and children with serious emotional disturbances. While initial funding arrangements to support community-based care reflected a significant degree of intergovernmental cooperation, such collaboration has steadily eroded, replaced by a seemingly endless struggle to shift costs and transfer financial risk.

Given an atmosphere of trust and an ethos of sharing (rather than shifting) risk, I would have suggested that the current 1915(b) waiver, the mental health component of the MiChild and ABW programs, and the above-referenced plan for a targeted (condition-based) eligibility expansion (using redirected DSH funds) *all be incorporated into a single 1115 managed care waiver*.¹⁸ I would propose differential funding adjustment arrangements over the five-year period of the waiver for Medicaid beneficiaries and targeted expansion populations. Funding adjustments for Medicaid beneficiaries (mandatory and optional categorically needy and the medically needy group) would adhere to the principle of actuarial soundness, promulgated in regulation and further articulated by CMS in their checklist for capitation rate setting. For the targeted expansion populations, there would also be funding adjustments, but I would suggest

¹⁵ For a discussion of special financing arrangements, see: Current Issues in Medicaid Financing – An Overview of IGTs, UPLs and DSH; Rousseau, D. and Schneider, A.; Kaiser Foundation (April 2004)

¹⁶ Medicaid Special Financing Payments and Intergovernmental Transfers; House Fiscal Agency (November 2000)

¹⁷ See the letter (dated June 25, 1998) to Michigan from Sally Richardson, Director of the Center for Medicaid and State Operations, Department of Health and Human Services

¹⁸ Montana attempted a variant of this approach in 1995. See Montana’s Mental Health Access Plan (June 1995), which was prepared by a Michigan firm, Health Management Associates

an *indexing method* that generates year-to-year changes in the relative proportions (according to economic circumstances) of federal, state *and local* contributions to the financing arrangements for this population. Local financial participation is essential; most care is now community-based and provided through local delivery systems. If local government does not participate in the financial arrangements for public mental health care, it cedes control of local services and circumstances to state and federal governments.

The indexing arrangement to determine the relative percentage paid by federal, state and local governments for the mental health care costs of targeted expansion populations would have to be much more sophisticated (and more fair) than those previously or generally used in making health care cost-related adjustments.¹⁹

One of the primary goals of this more comprehensive 1115 waiver proposal would be to move in the direction of a more unified and simplified funding framework for public mental health care. A further elaboration on this concept would be consideration of how to incorporate the behavioral health care services of Federally Qualified Health Centers (FQHCs) into the proposal. This would not only increase the breadth of the plan, but could also be a step in the direction of greater mental health – physical health care integration.

I would also request, as part of a comprehensive 1115 waiver, a significant relaxation of certain federal requirements that have been imposed on Medicaid managed mental health programs. CMS has applied (citing the discretionary authority of the Secretary) numerous requirements derived from the Balanced Budget Act (BBA) of 1997 to specialty managed care waivers such as Michigan's mental health program. The BBA statutory provisions were meant to regulate Managed Care Organization (MCOs) contracting with state Medicaid agencies to provide a comprehensive range of physical health care services. The application of these rules to specialty waivers imposes an immense (and expensive) regulatory burden that greatly complicates the operation of such programs. Other states with comparable mental health waivers (Pennsylvania, Utah, Washington) have made similar complaints about the hardship inflicted by this regulatory regimen, and have advocated for some relaxation or reinterpretation of these constraints.

Finally, if federal, state and local governments are committed to working collaboratively to address the needs of adults and children with mental illness, it would seem only fair to allow communities to utilize legitimate *savings* achieved through efficient management of the waiver to address locally defined mental health needs and priorities. If private sector MCOs contracting with the state for Medicaid managed physical health care can channel "profits" or "margins" to their owners, investors and/or shareholders, it seems reasonable and equitable to allow CMHSPs to reinvest saving for the benefit of their "stakeholders" – the community.

¹⁹ [The New Financial Order: Risk in the 21st Century](#), by Robert Shiller, Princeton University Press (April 2002)