CHRT
CENTER FOR HEALTHCARE RESEARCH & TRANSFORMATION

Community Mental Health Services: Coverage and Delivery in Michigan

October 2014

State and Federal Legislative History

Michigan's publicly funded mental health system has its origins in Public Act 54, signed in April 1963. This state law permitted counties to form Community Mental Health (CMH) boards to support and treat people with severe mental illness, developmental disabilities and substance abuse disorders outside of psychiatric hospitals and institutions.[1] Under this law, counties could create CMHs in conjunction with other counties or on their own. CMH funding was 60 percent local and 40 percent state.[2] Oakland County was the first Michigan county to establish a CMH and held their first board meeting in December 1963.[3]

At the federal level, President Kennedy signed the Community Mental Health Act (CMHA) in October 1963. The CMHA provided federal funding for the establishment of community mental health centers.[4] The Act appropriated funds for the construction of CMHs on the basis of population health need and the financial need of states.[5] The Act was intended to help states "provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor."[6] The CMHA started the trend toward deinstitutionalizing mental health patients.

In 1974, Michigan's P.A. 54 was repealed and replaced with Michigan P.A. 258, the Mental Health Code.[7,8] The Michigan Mental Health Code is the basis for Michigan's publicly funded mental health system today, allowing the creation of CMH agencies in single counties and CMH organizations in two or more counties. P.A. 258 further defined the role of CMHs and increased state matching funds to 90 percent.[9] In 1981, the Michigan Department of Mental Health (MDMH) created shared and full management contracts with CMHs.[10,11,12] In shared management contracts, MDMH and individual CMHs shared responsibility for planning and coordinating mental health services in a county. Under full management contracts, CMHs would take full responsibility for administering mental health services in their area. Previously, the state was responsible for all mental health services. Both of these provisions served to shift the responsibility for public mental health services to CMHs from MDMH. Under such contracts, CMHs were given more funding but assumed more responsibility for mental health care. CMHs were thus responsible for allocating state funding for services at state-run hospitals and centers and at community-based organizations.

Public Act 368 of 1978 amended the Public Health Code to create Substance Abuse Coordinating Agencies (CAs) in the state.[13] CAs do not deliver care directly but plan for and oversee public services for substance use disorders in the counties they serve.

The Center for Healthcare Research & Transformation (CHRT) illuminates best practices and opportunities for improving health policy and practice. Based at the University of Michigan, CHRT is a non-profit partnership between U-M and Blue Cross Blue Shield of Michigan designed to promote evidence-based care delivery, improve population health, and expand access to care.

www.chrt.org

In 1995, Public Act 290 repealed four of the Mental Health Code's (P.A. 258) original 26 sections.[14] Notably, P.A. 290 created an alternative designation for CMHs to exist as a government entity, independent from the county or counties that founded them. Initially, all CMHs were county agencies. The new designation would be known as a Community Mental Health Authority. Authorities were afforded powers that were not available to agencies such as owning and maintaining property, and constructing and operating facilities. Furthermore, employees of a CMH authority are employees of the CMH authority itself and not of the county that created it. As such, authorities could operate independently from county government, reporting to a 12-member board appointed by county commissioners.

In the mid-1990s, Michigan began to transition Medicaid recipients to managed care. At that time, the state elected to create a "carve-out" for behavioral health services.[15] The behavioral health carve out was created under federally approved waivers 1915(b) and 1915(c) under the Home and Community Based Services Waiver to the Social Security Act. By 1998, these carve-outs became known as Prepaid Inpatient Health Plans.[16] The PIHP model is a federal designation that exists in 20 states, including Michigan. PIHPs must provide coverage for Medicaid recipients suffering from mental health issues, developmental disabilities, substance abuse or serious emotional disturbances. Each PIHP must cover at least 20,000 Medicaid beneficiaries.

In 2000, Public Act 130 amended P.A. 258 to expand the definition of a CMH organization known as a "CMHSP Organization" under the Urban Cooperation Act.[17] CMH organizations could now be formed between one or more counties and an institute of higher education with a medical school. The organization would still be a governmental entity separate from the bodies that formed it. This amendment was put in place specifically to enable the formation of the Washtenaw Community Health Organization. *Appendix A* provides more detail on the distinction between authorities, agencies and organizations.

Most recently, in 2012, Public Acts 500 and 501 amended P.A. 258 to require that by October 1, 2014, all CAs will be merged with PIHPs in the state, reducing the number of CAs in the state to 10.[18]

Overview of Current Structure of Public Mental Health Care in Michigan

Mental health care delivery in the state has changed forms many times since the early 1960s. In 1965, the state of Michigan operated 41 psychiatric hospitals and centers for persons with developmental disabilities, serving approximately 29,000 residents. As a result of deinstitutionalization, by 1991, 29 state hospitals and centers served 3,054 residents. As of March 2014, only five state-operated psychiatric hospitals and centers were operating in Michigan.[19]

Since 1965, the number of CMHs has increased from 12 covering 16 counties to 46 covering all 83 counties in the state.[20] Today, Medicaid is the major source of most funding for Michigan's publicly funded mental health system, and care at CMHs is an entitled benefit under Medicaid. As such, individuals with Medicaid coverage are more likely to receive care through CMHs than uninsured and underinsured individuals. Furthermore, CMHs providing care for non-Medicaid covered individuals must use limited state general fund dollars to cover their care.

State general fund dollars are allocated to each CMH based on historical funding formulas that are modified at the state's discretion. Changes to the allocations have related to administrative expenses, previous general fund transfers between CMHs (under Public Act 236), and an effort to bring all CMHs to the same level of funds based on county populations. Beginning in 2014, general fund dollars to CMHs were reduced substantially as a result of the state's decision to expand Medicaid under the Patient Protection and Affordable Care Act.[21] Medicaid funds are allocated monthly to each CMH through PIHPs according to the number of Medicaid beneficiaries in the PIHP's service area. Decreases in general funds in recent years have threatened the ability of CMHs to deliver care to many of those in need. (See *Appendix B* for details about the flow of funding streams.) That is, only non-Medicaid patients with the most severe mental illness or developmental disabilities ("priority populations" under the Michigan Mental Health Code) receive care through CMHs. Non-Medicaid eligibles may also

be subject to waiting lists at CMHs, while individuals covered by Medicaid are not.[22] Emergency cases are an exception, and are treated immediately regardless of a person's ability to pay. Of the 227,020 people served at CMHs in Michigan in 2010, 69 percent were covered by Medicaid.[23]

Administrative Bodies

Three different types of organizations manage and administer Michigan's publicly funded mental health system: Prepaid Inpatient Health Plans (**PIHPs**), Community Mental Health Services Programs (**CMHs**), and Substance Abuse Coordinating Agencies (**CAs**). Each type of organization is described below. (See *Appendix C* for current CMHSPs*, and Appendix D* for PIHP and CA areas as of January 2014.)

PIHPs are Medicaid behavioral health managed care organizations that administer capitated funds, bear risk for Medicaid patients (7.5 percent for regular Medicaid beneficiaries and 100 percent for those covered under the Adult Benefit Waiver program), and manage Medicaid patients' behavioral health care. Medicaid funds are allocated to PIHPs based on the number of Medicaid beneficiaries in the PIHP service area, and PIHPs pay providers directly. Providers include CMHs themselves as well as community-based providers under contract with a CMH or CA. PIHPs receive monthly, capitated payments from MDCH for the Medicaid Managed Mental Health Care Program. In addition to issuing Medicaid payments to doctors, hospitals, other community providers and CMHs, PIHPs may perform gate keeping and authorization services and monitor health outcomes and standards of care.

Currently there are 10 PIHPs throughout Michigan, and each PIHP is affiliated with at least one CMH. The 10 PIHPs oversee the 46 CMHs that serve all 83 counties in the state. Each PIHP is responsible for an area with at least 20,000 Medicaid beneficiaries. Three (3) PIHPs are responsible for one county and a corresponding CMH. Seven (7) PIHPs are responsible for 4 to 21 counties. (See *Appendix F* for PIHP funding and spending in 2010.) Beginning January 2014, the previous 18 PIHPs were consolidated to the 10 new PIHP regions in the state.

CMHs provide direct mental health care or contract with community providers to do so. Although each CMH is affiliated with a PIHP, the structure of each CMH varies throughout the state (see *Appendices C and D* for CMH, PIHP, and CA coverage areas, respectively). Of the 46 CMHs, 37 are designated as Authorities, seven as Agencies of county government, and two as Organizations. The two CMH organizations are the Washtenaw Community Health Organization (WCHO) and the Central Wellness Network in Manistee/Benzie counties. WCHO was the first CMH to become an organization under the Urban Cooperation Act.

CAs provide comprehensive planning for substance abuse treatment, rehabilitation (recovery) and prevention services, but are prohibited from directly providing services. Instead, CAs contract with community providers for service delivery. When CAs merge with the 10 realigned PIHPs in October 2014, all PIHPs will be responsible for the coordination of substance use disorder services.[24,25]

Emerging Models: Integrated Care for Dual Eligibles—Michigan's Demonstration Pilot Proposal

Dual eligibles, persons eligible for both Medicare and Medicaid, present some of the most complex and costly cases in the Medicaid system. In 2011, the Centers for Medicare and Medicaid Services selected Michigan as a demonstration site to integrate care for dual eligible individuals, and a Memo of Understanding was signed between CMS and MDCH in April 2014. The new plan, designed as a three-year pilot starting in July 2014, will be implemented in four regions of the state: a region in the southwest part of state including Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties; Macomb County; Wayne County; and the entire Upper Peninsula. The pilot program will create a delivery and payment

model that will integrate clinical, long-term care, behavioral and support services into a managed care model, a major change from the current fee-for-service system. All dual eligibles can opt out of the pilot and continue their current fee-for-service care.

With regard to mental health services, PIHPs in Michigan will continue their current responsibilities for meeting dual eligibles' behavioral health needs. However, clinical and long term care will be managed by Integrated Care Organizations (ICOs) that contract with PIHPs. Under the pilot, ICOs and PIHPs will work together via a "Care Bridge" to coordinate behavioral, clinical and long term care supports and services with a goal to provide higher quality and more efficient care. Each multi-disciplinary team that makes up a Care Bridge will be led by a services or support coordinator who will coordinate all care according to each individual's particular needs. The coordinator will be associated with either the PIHP or ICO, depending on the individual's needs. For example, if a person has a developmental disability, the coordinator of their Care Bridge team would likely be associated with the PIHP. See *Appendix E* to view the Care Bridge model.

The demonstration will create a three-way contract between: (1) ICOs and PIHPs, (2) the state, and (3) the federal government to manage, coordinate, and pay for all services for dual eligibles. Capitation payments to PIHPs will be based on three separate rate structures for mild to moderate mental health needs, intellectual/developmental disability, and serious mental illness.

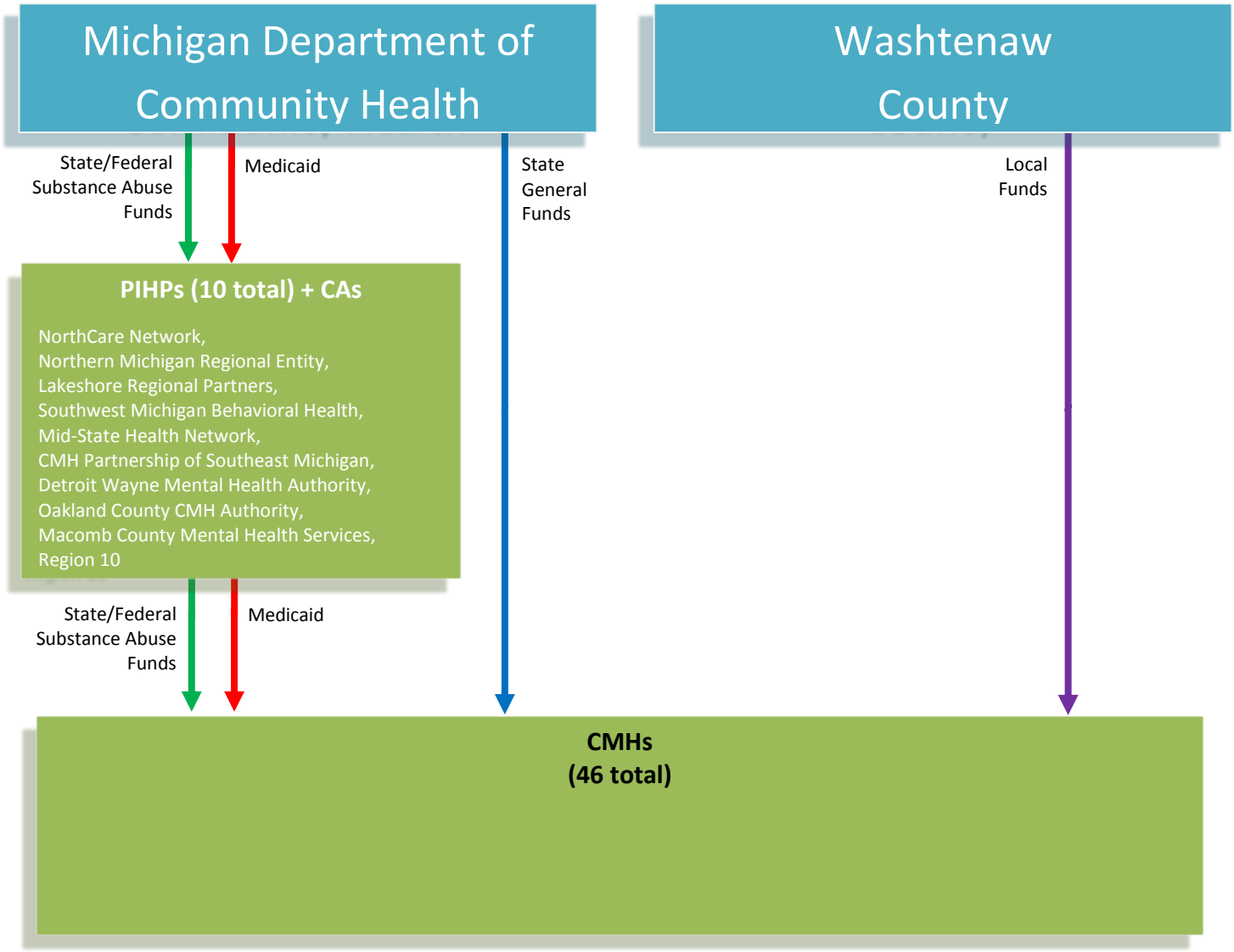
Authors: Ederer, D., Baum, N., and Udow-Phillips, M. 2013. Center for Healthcare Research & Transformation. Revised October 2014.

Appendix A: Structure of Community Mental Health Agencies, Authorities, and Organizations

	CMH Agency	CMH Authority	CMH Organization
Legal	Formed by one or more counties and is an entity of the county. Agency employees are county employees.	Formed by one or more counties as a non-profit, and is legally separate from the county or counties that formed it. Authorities may own property and enter into contracts. Authority employees work for the Authority itself, not the counties.	Formed by two or more counties or at least one county and an institute of higher education. Legally separate from the bodies that formed it. Organizations may own property and enter into contracts. Employees work directly for Organizations, not for counties.
Governance	12-member board, appointed by county commissioners or county CEO in charter counties.	12-member board, appointed by county commissioners or county CEO in charter counties.	12-member board, with equal representation from each governing body.
Financial Reporting	Reported as a special revenue fund of the county and included as a portion of county financial statements.	Reported as separate entity from counties and has its own financial statements. May be considered as a component unit of a county and included on county financial statements.	
Funding Sources	State contracts and external grantors, general taxes or special taxes appropriated for CMHs, general obligation or revenue bonds subject to municipal finance act, fundraising and donations.	State contracts and external grantors, county appropriations, installment purchase agreements and revenue anticipations (cannot issue bonds), fundraising and donations. Unlike agencies, counties with authorities and organizations cannot levy taxes to directly support CMH. Authorities have a limit on county matching funds that is not imposed on Organizations	

SOURCE: Center for Healthcare Research & Transformation

Appendix B:
Funding Streams for Michigan's Public Mental Health System

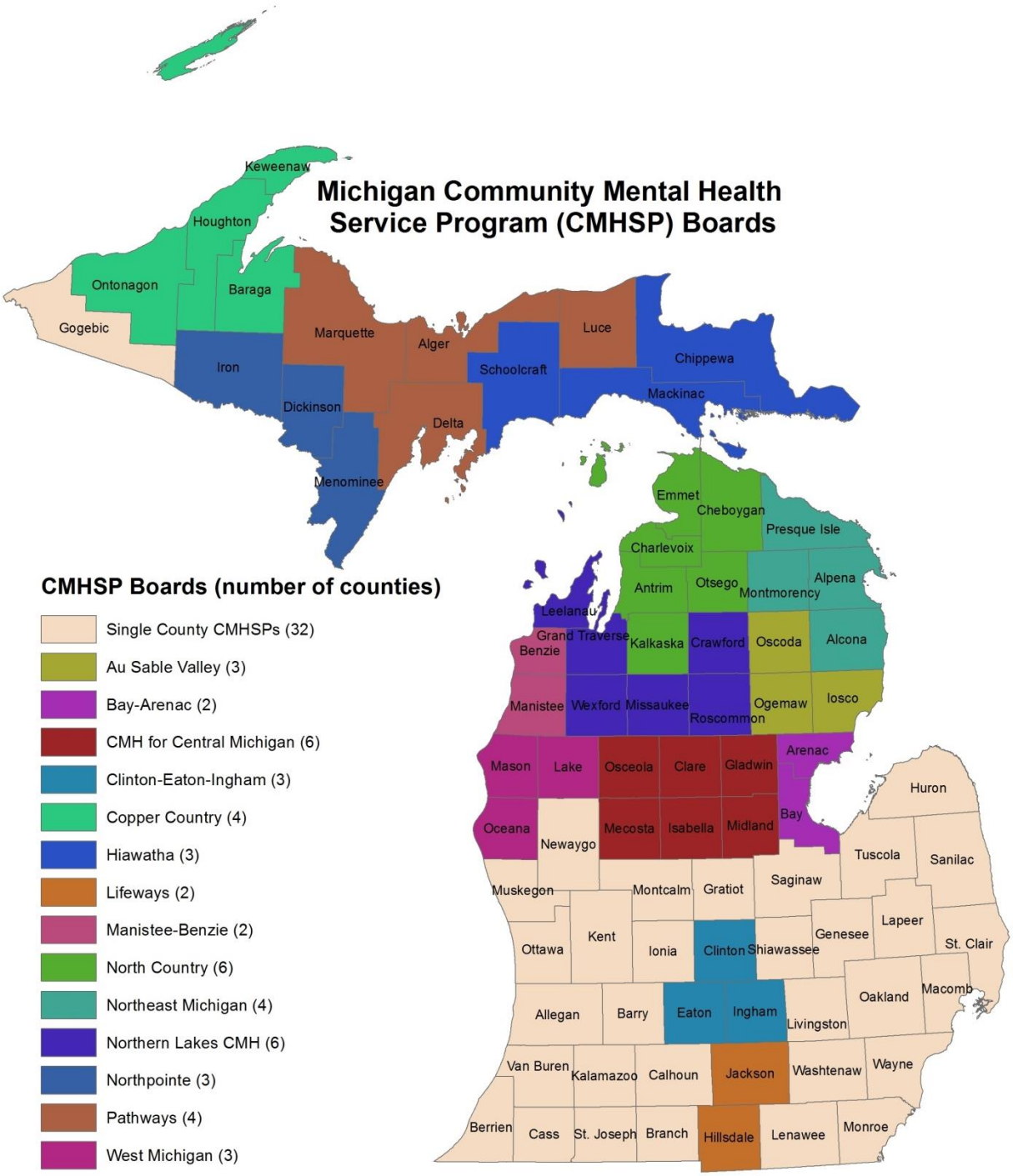


PIHP = Prepaid Inpatient Health Plans
CMH = Community Mental Health Services Programs
CA = Substance Abuse Coordinating Agencies

SOURCE: Center for Healthcare Research & Transformation

Appendix C: CMHSP Boards

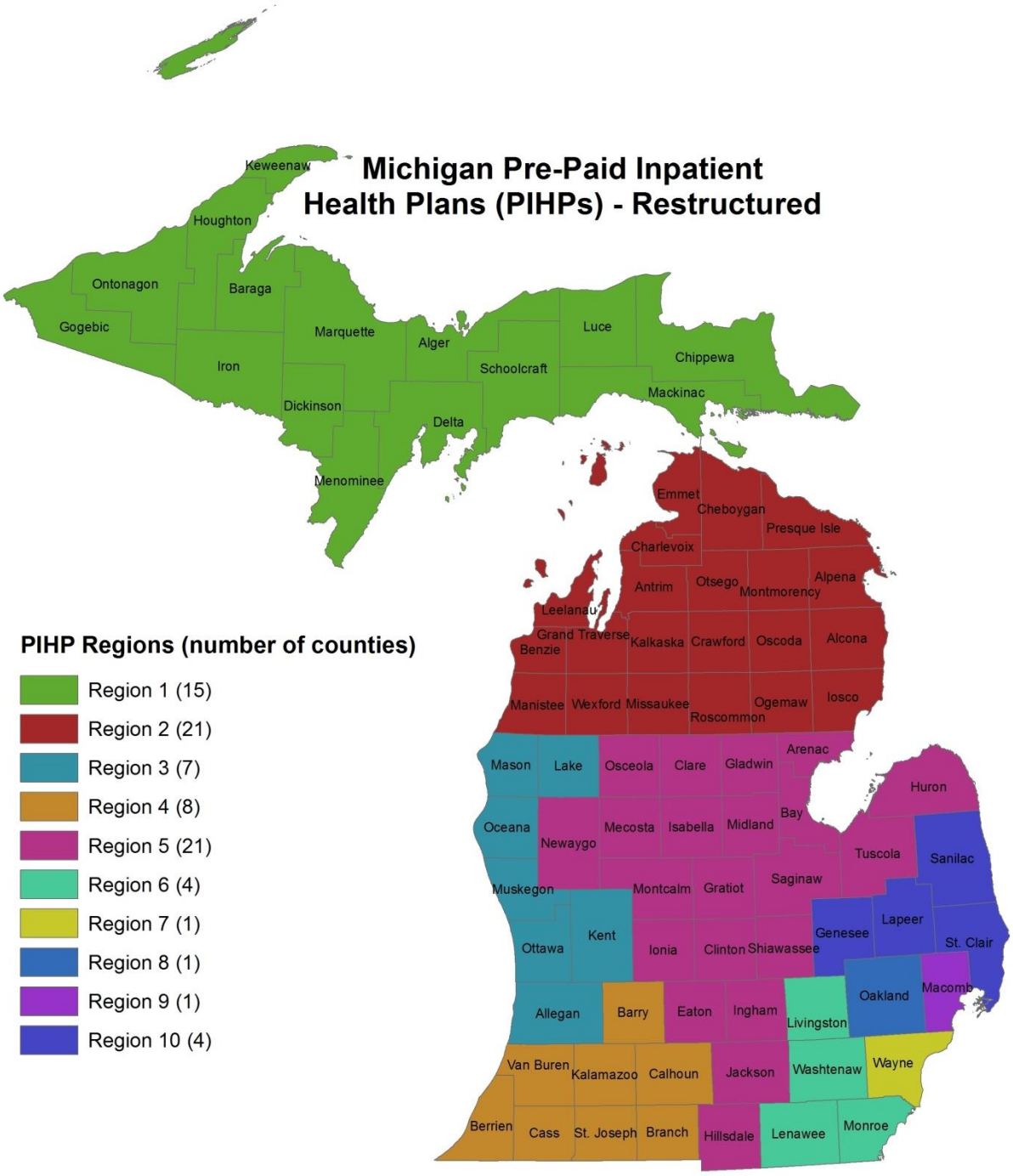
The map below shows which CMHs currently cover each county in Michigan. CMHs that are responsible for a single county are shown in beige. Colored counties are covered by a multi-county CMH. There are 46 CMHs covering all 83 Michigan counties.



SOURCE: Michigan Department of Community Health, Behavioral Health Developmental Disabilities Administration
https://www.michigan.gov/documents/mdch/BHDDA_Budget_FY2014_-_Senate_412754_7.pdf

Appendix D: PIHP and Coordinating Agency Coverage in Michigan

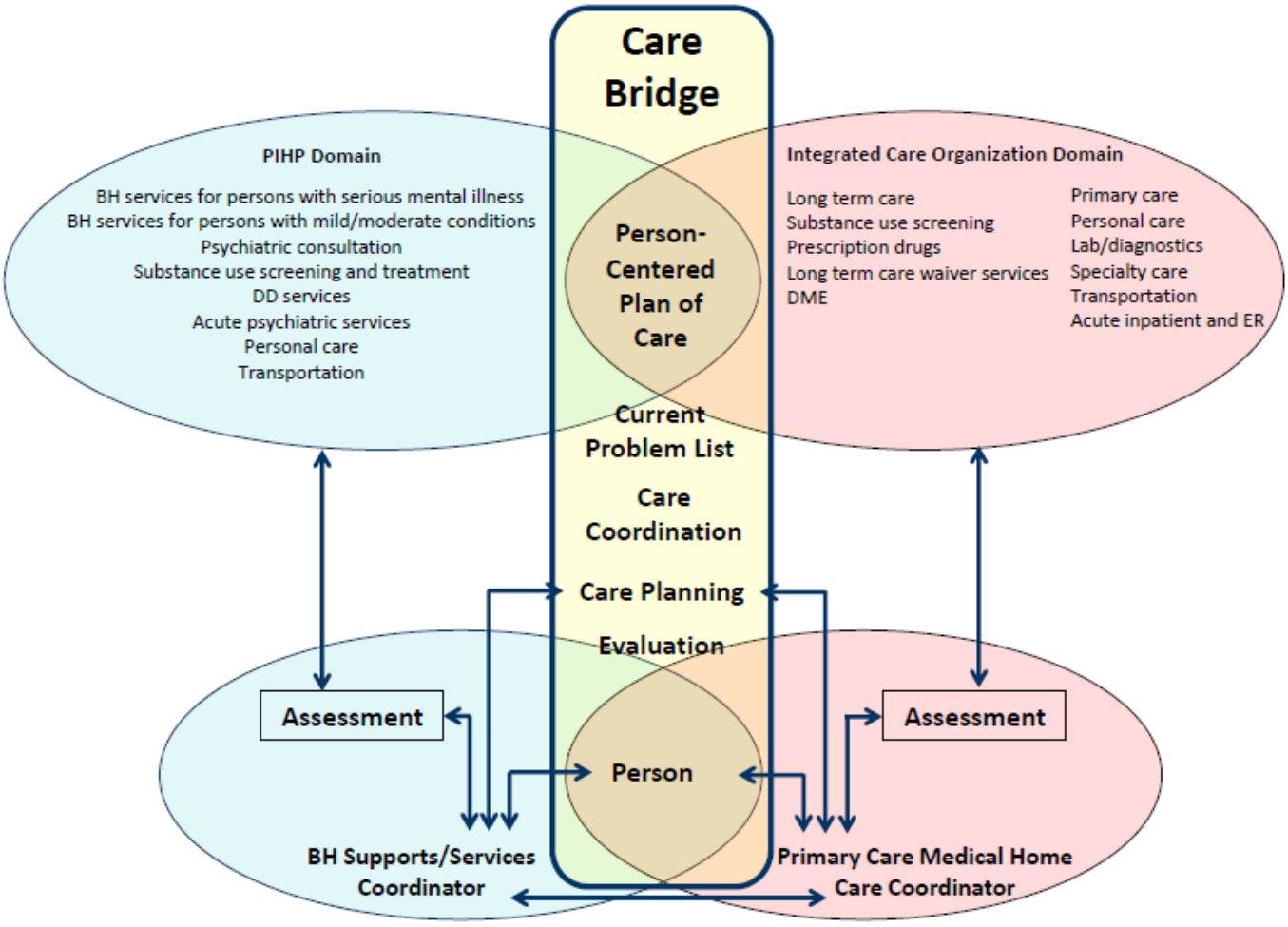
The map below shows the new PIHP and CA coverage areas in Michigan, beginning January 1, 2014. Currently there are 10 PIHPs that are responsible for 46 CMHs covering all 83 Michigan counties.



SOURCE: Michigan Department of Community Health, Behavioral Health Developmental Disabilities Administration
https://www.michigan.gov/documents/mdch/BHDDA_Budget_FY2014_-_Senate_412754_7.pdf

Appendix E: The Care Bridge Model

The figure below displays the Care Bridge model from the MDCH dual eligibles pilot. The shapes in the diagram represent PIHPs, ICOs and the Care Bridge team between them. The text inside each shape delineates the services each entity will be responsible for managing under the pilot. In short, ICOs will be responsible for long term and primary care for dual eligibles while PIHPs will manage the behavioral health services for this population. Care Bridge teams will be responsible for coordinating care between PIHPs and ICOs.



SOURCE: Michigan's Proposal: Integrated Care for People who are Medicare-Medicaid Eligible http://www.chcs.org/usr_doc/MichiganProposal.pdf.

Appendix F: PIHP Funding and Spending, 2010

The table below shows Medicaid funds available and expenditures for each PIHP in 2010 (most recent data available).

PIHP Funding and Spending, 2010										
			Medicaid MH/DD/SA Total Expenditures		Medicaid Managed Care MH/DD/SA Administration Expenditures					
PIHP	FY10 Available Medicaid Resources[1]	Total MH/DD/SA Medicaid Cases	Amount[2]	$$/ Consumer	Amount[3]	Percentage of Total Medicaid Resourses	$$/ Consumer	Savings at Year End	Internal Services Fund (ISF)[4]	Lapse
Access Alliance	$87,198,756	8,014	$84,571,899	$10,553	$7,473,071	8.57%	$933	$2,205,809	$6,261,007	
CMH Affiliation of Mid-MI	$109,330,239	8,964	$107,022,366	$11,939	$4,491,212	4.11%	$501	$2,074,621	$1,804,898	
CMH for Central Michigan	$69,241,387	6,983	$65,674,490	$9,405	$5,147,466	7.43%	$737		$3,622,818	
Detroit-Wayne	$443,214,221	45,875	$405,512,284	$8,840	$36,500,229	8.24%	$796	$19,014,210	$14,695,815	
Genesee	$103,951,269	10,029	$101,386,874	$10,109	$6,525,763	6.28%	$651		$3,640,193	
Lakeshore Affiliation	$72,168,656	6,063	$68,532,038	$11,303	$3,699,862	5.13%	$610	$4,510,373	$3,118,643	
Lifeways	$40,852,117	4,758	$38,443,266	$8,080	$3,831,672	9.38%	$805	$2,232,200		$189,593
Macomb	$160,816,943	11,688	$151,726,419	$12,981	$7,513,281	4.67%	$643	$5,680,327	$11,990,437	
Network 180	$98,242,615	10,148	$98,160,847	$9,673	$7,031,416	7.16%	$693		$2,461,985	
Northcare	$90,074,715	5,192	$85,554,326	$16,478	$2,658,353	2.95%	$512	$5,516,613	$6,141,798	$1,246,328
Northern Affiliation	$68,081,934	5,835	$64,534,532	$11,060	$2,804,701	4.12%	$481	$516,787	$3,307,474	
Northwest	$55,176,333	5,581	$52,006,623	$9,319	$3,156,587	5.72%	$566	$784,075	$4,112,671	
Oakland	$240,336,065	12,952	$232,721,264	$17,968	$12,489,728	5.20%	$964	$6,339,727	$16,426,546	
Saginaw	$44,536,703	3,915	$44,998,094	$11,494	$2,802,257	6.29%	$716			
Southeast Partnership	$112,318,547	8,521	$103,164,712	$12,107	$5,233,799	4.66%	$614	$2,692,006	$6,663,245	
Southwest Affiliation	$91,352,928	8,052	$90,395,055	$11,226	$7,528,266	8.24%	$935		$6,630,595	
Thumb Alliance	$80,324,436	5,696	$75,741,050	$13,294	$2,706,949	3.37%	$475	$3,850,562	$5,735,854	$26,658
Venture	$92,769,043	10,467	$88,508,248	$8,456	$5,791,920	6.24%	$553	$3,885,795	$4,889,408	
State Total	**$2,060,016,906**	**178,733**	**$1,958,654,384**	**$10,959**	**$127,386,532**	**6.18%**	**$713**	**$59,393,105**	**$101,233,387**	**$1,462,579**

SOURCE: Michigan Department of Community Health, 2011 Fingertip Report: PIHP Medicaid Cost Summary http://www.michigan.gov/documents/mdch/A_-_MH_DD_SA_Cost_Summary_FY10_362802_7.pdf.

[1] Community Mental Health Services Program (Public Act 54 of 1963). Michigan Legislature. Accessed 23 July 2012. http://legislature.mi.gov/doc.aspx?mcl-act-54-of-1963
[2] P.A. 54.
[3] Financial Statements 2007-08. February 3, 2009.Oakland County Community Mental Health Authority. http://www.michigan.gov/documents/treasury/637591OaklandCoCommMHAuth20090310_270255_7.pdf (accessed 7/23/12).
[4] *Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Sections 200-207 Brief title: Community Mental Health Act of 1963).* (PL 88-164, 31 Oct. 1963).. http://history.nih.gov/research/downloads/PL88-164.pdf (accessed 7/24/12).
[5] P.L. 88-164. Section 202.
[6] P.L. 88-164. Section 203.
[7] P.A. 54.
[8] Mental Health Act (Public Act 258 of 1973). Michigan Legislature. http://legislature.mi.gov/doc.aspx?mcl-Act-258-of-1974 (accessed 7/24/12).
[9] P.A. 258 Chapter 3, Section 302.
[10] Financial Statements 2007-08. February 3, 2009. Oakland County Community Mental Health Authority.
[11] Bay Arenac Behavioral Health Association. 2011. *History of Organization.* http://www.babha.org/Docs/History%20of%20Organization.pdf (accessed 7/24/12).
[12] Michigan Mental Health Commission. October 15, 2004. *Final Report*. http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4902-270040--,00.html (accessed 7/24/12).
[13] Public Health Code (Public Act 368 of 1978, Article 6). Michigan Legislature. http://legislature.mi.gov/doc.aspx?mcl-368-1978-6-62 (accessed 7/24/12).
[14] Amendment to the Mental Health Act. (Public Act 290 of 1995). Michigan Legislature. http://legislature.mi.gov/doc.aspx?1995-SB-0525 (accessed 7/24/12).
[15] MHC Executive Report 2004.
[16] Financial Statements 2007-08. February 3, 2009.. Oakland County Community Mental Health Authority.
[17] Public Act 130 of 2000. Michigan Legislature. http://legislature.mi.gov/doc.aspx?2000-SB-1006 (accessed 7/23/12).
[18] Public Act 500 and Public Act 501, Michigan Legislature. http://legislature.mi.gov/doc.aspx?2012-PA-0501 (accessed 11/21/2013).
[19] Haveman, J., Zeller, L, and Becker, T. 2014. Michigan Behavioral Health Developmental Disabilities Administration. http://www.michigan.gov/documents/mdch/BHDDA_Budget_FY2015_-_HOUSE_-_FINAL_449479_7.pdf
[20] Haveman, Zeller and Becker, 2014.
[21] Patient Protection and Affordable Care Act. 2010, Pub. L. No. 111-148, 124 Stat. 119. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf (accessed 10/28/14).
[22] J. Taylor. N.d. *CMH Financing History: Summary of 20 Years of the State Financing Strategy for CMH*. www.michigan.gov/documents/CMH_FINANCING_HISTORY_92807_7.doc (accessed 8/16/12).
[23] Dazzo, Lyon, and Becker, 2012.
[24] Financial Year 2008 Appropriation Bill (Public Act 123 of 2007). Michigan Legislature. http://www.michigan.gov/documents/mdch/4702_5_1_08_246082_7.pdf or http://legislature.mi.gov/doc.aspx?2007-HB-4344 (Act in full), accessed 7/24/12.
[25] Financial Year 2012 Appropriation Bill (Public Act 63 of 2011). Michigan Legislature. http://www.michigan.gov/documents/mdch/4074_04_01_12_382343_7.pdf or http://legislature.mi.gov/doc.aspx?2011-HB-4526 (Act in full).