FUNDING COMMUNITY MENTAL HEALTH IN MICHIGAN

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Contents

Tables

Figures

Foreword

In December 1994, the Citizens Research Council of Michigan was engaged by the (then) Department of Mental Health and a statewide consortium of foundations to assist the Department in formulating a new means of distributing state dollars to local Community Mental Health boards.

Since that time, mental health policy development has proceeded at a rapid pace. Late 1995 saw the passage of the revised mental health code, with its options for organizing CMH delivery. Early 1996 brought with it a massive reorganization of health-related functions into the Department of Community Health. And presently underway is the adoption of managed care in the delivery of mental health services, possibly the most important change since the move to community-based care began in the early 1960s.

The fluid nature of mental health care policy in the last two years has had its impact on the development of a means of more equitably and efficiently distributing nearly $1 billion per year in funds to CMH boards. Initially, the effort involved a determination of need for care based on estimates of serious mental disorder and on developmental disability caseloads. This was intended to relate the funding to the prevalence of the conditions at which CMH programming is aimed.

In creating a managed care plan under Medicaid, however, inclusion of factors more closely related to low-income target groups became important, so Medicaid caseloads and the level of the uninsured population in each CMH catchment area were added as factors in determining the distribution of CMH dollars.

The dynamics of the process that has been put into motion will almost certainly result in a greatly changed landscape for the delivery of CMH services in the future. More extensive privatization of service delivery, merged CMH boards, and a greater role for the Department of Community Health as contract manager are all likely outcomes of a full-blown policy of managed care. A sound means of distributing funds under this policy is critical.

Citizens Research Council of Michigan would like to express its appreciation of support for this project to the following: Metro Health Foundation; Midland Foundation; Community Foundation of Greater Flint; the Grand Rapids Foundation; Muskegon County Community Foundation; Battle Creek Community Foundation; the Fremont Area Foundation; Rotary Charities of Traverse City; Steelcase Foundation; Community Foundation for Southeast Michigan; and the Michigan Association of Community Mental Health Boards, as well as the Michigan Department of Community Health.

We would also like to thank Ralph Michener and Jane Michener of Michener and Michener for their contribution to the development of the measurement of serious mental disorder that underlies a portion of the formula described in this report.

FUNDING COMMUNITY MENTAL HEALTH IN MICHIGAN

I. Introduction: The Objectives of a Funding Formula

The allocation of dollars from the state to Community Mental Health boards evolved over twenty years as a result of historical factors having to do with the timing of the adoption of full management contracts with the state, the character of budget submissions by various CMH boards, and, to an extent, political considerations. A process is needed whereby CMH dollars are distributed in a more equitable manner and which facilitates a move to managed care.

A. Funding Formula Objectives.

A reformulated distribution of dollars should incorporate elements that reflect state objectives for fund distribution. These objectives include:

- Adequate funding of effective services
- Maintenance of community responsibility and authority for implementing state and local priorities
- Equitable distribution of CMH dollars
- Promotion of the development of innovative programs.

In addition to supporting these objectives, a new funding formula must take into account other developments that are either underway or are reasonably likely to occur. Principal among these are the adoption of managed care systems at both the state and federal levels and the possibility of a move to block grants by the Federal Government.

B. Funding Formula Criteria.

In this light, CRC set out five criteria for a workable funding formula:

1. *A formula should be as simple as possible.* Any formula that strives to create equity is very likely to include elements that will increase its complexity. A straight per capita distribution would very likely be the simplest, but it would not take into account factors known to influence the need for and utilization of CMH services. At the same time, the demands for data in a complex formula could create problems and expense without a commensurate increase in distributional equity. Moreover, there are those with policy making and oversight roles who may need to understand the formula as part of their responsibilities. A complex, technical formula would impede such understanding.

2. *A formula should be neutral with respect to treatment choices.* Granted that treatment decisions are made in the context of limited resources, a formula should not penalize the adoption of certain kinds of treatment that, in the judgment of the providers, are in the best interests of the clients. Similarly, a formula should not provide incentives for irrational use of resources.

3. *A formula should allow for maximum flexibility in using funds to meet local conditions within the context of overall state priorities.* In the same vein, the formula should allow local boards to direct the maximum amount to client needs and should not reward non-treatment expenditure.

4. *A formula should be based on data that either are currently available or that can be made available within a reasonable period of time.* Central collection of data by the State has been inconsistent over the years and CMH boards have devised a number of different systems to track their programs. Definitions among boards have been inconsistent and the kinds of information have varied. In specific instances, this information may provide an ability to assess the service delivery and funding requirements of a given CMH board. Unfortunately, a funding formula requires data that are consistent across the state.

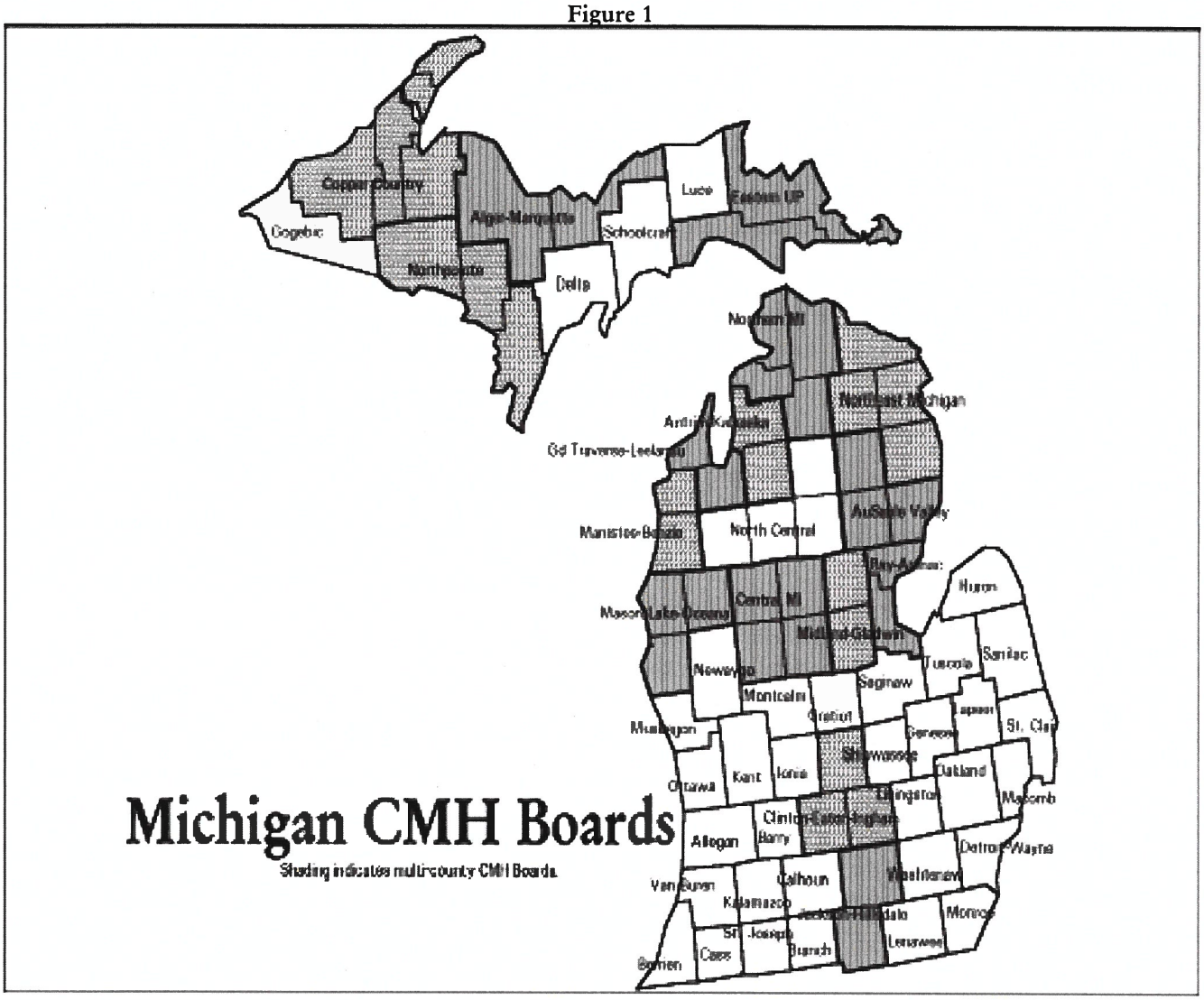
5. *A formula should permit each CMH board to adequately serve the same level of need.* In other words, no CMH board should have resources to serve a less needy population until all other CMH boards have similar resources. It may be that such difficult-to-measure factors as management capacity or selection of treatment methods will affect the actual ability of a CMH board to provide a given level of service with a given level of resources. Nevertheless, this should not detract from the basic goal of equitable distribution of state resources.

C. Utilization and Need.

A basic problem to be addressed by a new funding formula is the accommodation of actual utilization and need. The measurement of actual utilization, while it involves a number of problems (e. g., What is a case?), is substantially more precise than the measurement of

need. Almost certainly, however, utilization reflects capacity as well as demand for service so that funding based on utilization alone is likely to continue any existing inequities.

Figure 1



II. Community Mental Health in Michigan: A Primer

A. Origins of Community Mental Health

Until the early 1960s, the treatment of mental disorders was carried out primarily in "mental institutions." The goal was to "cure" the mentally ill by removing them from the environment to which they had become accustomed. Failing a cure, mental hospitals functioned as custodial institutions which kept the patient and the outside world apart.

Beginning in 1962, however, largely at the prompting of the federal government, Michigan and the other states developed community-based mental health programs and began the process of shifting the locus of care away from the institutions to community-based providers of care.

This shift occurred when it did for three basic reasons:

1) The advent of an array of psychotropic drugs made it possible to permit a large number of individuals who previously would have been institutionalized to function independently;

2) The growth of public assistance provided previously indigent individuals with the financial resources necessary to live independently, thus eliminating the "poor house" role of the mental institution;

3) Large institutions came to be viewed as isolating patients from their accustomed surroundings, thereby creating an artificial treatment environment and instilling in the patient a dependence on the institution, further complicating rehabilitation.

A community mental health program, however, was designed to help clients remain in their own communities with services provided to them and their families.

One of the presumed benefits of community-based programs was that preventive activities appeared to be a natural fit for the new approach. Prevention was to occur at two levels. First, activities designed to deal with societal or community conditions that were associated with mental disorder were to be undertaken. Second, activities aimed at the individual (pre-natal care, screening, etc.) were to be developed.

Although prevention initially received a great deal of emphasis in the literature associated with community mental health and in the public policy related to it, a recognition of the limitations of preventive activities led to a gradual reduction in the relative importance of preventive activities and, while prevention still receives resources, the preponderance of funds and programs are aimed at treatment.

B. Community Mental Health in Michigan

Community mental health services are provided by 52 CMH boards covering the entire state. They are funded by a combination of state, local, federal, and private sources. The services are provided under contract with the Michigan Department of Community Health to three principal groups--adults with mental

Table 1

Community Mental Health Appropriation
State of Michigan, Fiscal Year 1996-97
(dollars in millions)

Appropriation Title	State GF-GP	Federal Medicaid HCFA-XIX	Federal Medicaid OBRA-XIX	Federal MH Block Grant	Public Health	Total
CMH Operations	$ 629.2	$ 276.4	$ -.-	$ -.-	$ -.-	$ 905.6
CMH State Services Purchase	281.1	-.-	-.-	-.-	-.-	281.1
MH Federal Block Grant	-.-	-.-	-.-	10.7	-.-	10.7
OBRA Implementation	3.7	-.-	6.6	-.-	-.-	10.3
Community Demand Beds	6.8	2.4	-.-	-.-	-.-	9.2
Respite Care	0.4	-.-	-.-	-.-	3.0	3.4
Total	$ 921.2	$ 278.8	$ 6.6	$ 10.7	$ 3.0	$ 1,220.3

Source: Department of Management and Budget.

illness, children with mental illness, and the developmentally disabled.

Although a significant amount of the financial support of the CMH program comes from Medicaid, the federal-state program of medical care assistance to those with low incomes, the newly-revised mental health code provides that:

> The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay.

Since its inception, the CMH program has been a key part in one of the most dramatic transformations in the history of state government. In a period of a little over 30 years, the state has reduced the level of institutional care by 90 percent and has shifted the focus of care to the communities. To fully understand the present role of CMH, an understanding of the history of the program is desirable.

1. Legal Background

The authority of the state to enact laws providing for the treatment of the mentally ill and the developmentally disabled is encompassed within the police power, which is that power inherent in state government to protect the health, safety, general welfare of its citizens.

a) State Constitutional Provisions.

While the police power merely permits legislative enactments in furtherance of health, safety, and general welfare, the 1963 Michigan Constitution (which was adopted at the very beginning of the rise of community mental health) directs the Legislature to support mental health programs. Section 8 of Article 8 provides:

> Institutions, programs and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally or otherwise seriously handicapped shall always be fostered and supported.

The move toward community-based care was anticipated in the 1963 Constitution because the requirements of the 1850 and 1908 Constitutions regarded institutions as the exclusive means of treating the mentally ill. The delegates to the 1961 Constitutional Convention, having concluded that such a restrictive focus was no longer appropriate, added language that declares that not only "institutions" but also "programs and services" are to be "fostered and supported."

b) Act 54 of 1963.

The Michigan Legislature implemented these constitutional provisions by enacting a mental health code setting forth the basic statutory framework for mental health services. Chapter 2 of the code (Act 258 of 1974) dealt with community mental health programs and was the direct lineal descendant of Public Act 54 of 1963, the Community Mental Health Services Act. (CMH boards are sometimes still referred to as "Act 54 boards.") Act 54, adopted in response to developments at the federal level, authorized counties or a city with a population of at least 500,000 (Detroit) to establish community mental health programs to provide a range of inpatient and outpatient services for diagnosing and treating mental illness. A unit of local government establishing a community mental health program was required to appoint a 12-member board to oversee its operations.

Act 54 authorized the Department of Mental Health to assist in the establishment and operation of community mental health programs by providing matching grants. In addition, local mental health programs could apply to the department for ongoing financial assistance by submitting an annual budget and plan of care. At the beginning of each state fiscal year, the department was required to allocate available state funds to community mental health boards in accordance with those budgets and plans of care approved by the department.

Under Act 54, CMH programs received 75 percent of their support from the state, with the remainder provided by the counties.

Act 54 had a significant impact on the transition from institutionalized care to community-based care. Within nine years after the act was adopted, 50 counties containing 90 percent of the state's population had established community mental health programs. State appropriations to community mental health under Act 54 rose from $12.7 million in Fiscal Year 1964-65 to $39 million in FY75.

c) The Mental Health Code: Public Act 258 of 1974.

After four years of development, the Legislature passed Public Act 258 of 1974, the mental health code. The new code consolidated a number of then-existing public acts dealing with mental health, repealed 25 public acts in their entirety (including Act 54), and repealed several sections of four other public acts.

A Bureau of Community Mental Health Services, responsible for administering the various contracts entered into between the department and the community mental health boards, was created under the authority of the code. The Bureau of Forensic Mental Health Services was set up in 1992 to administer mental health services provided to inmates of state correctional facilities. The Bureau of Hospitals and Centers was made responsible for services provided in the state-operated psychiatric hospitals and developmental disabilities centers.

The code provided for the following powers for the Department of Mental Health:

- Provide services to individuals giving priority to the areas of mental illness and mental retardation:
- Administer the community mental health program, with the objective of shifting primary responsibility for the direct delivery of public mental health services from the state to a community mental health 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."
- Engage in mental health needs assessment.
- Coordinate and integrate all public mental health services and develop cooperative arrangements between public and nonpublic services for the purpose of providing a unified system of statewide mental health care.
- Evaluate the relevance, quality, effectiveness, and efficiency of mental health services provided by the department and assure the review and evaluation of community mental health services. The department was to "establish a structured system to provide data necessary for the review and evaluations."
- Establish training and experience standards for executive directors of community mental health programs.
- Support research activities.
- Support training, consultation, and technical assistance for community mental health service providers.
- Support multicultural services.

Under the code as passed in 1974, a county or combination of counties could elect to establish a community mental health program, operated under the auspices of a community mental health board consisting of 12 members appointed by the county commissioners (except in Wayne County, in which six members are appointed by the Mayor of Detroit) for three-year overlapping terms.

Each community mental health board was required to examine and evaluate both the mental health needs in its area and the services necessary to meet those needs. As part of this process, the statute required each board to develop an annual plan and budget for its programs to be submitted to the board of county commissioners and, upon approval by that body, to the Department of Mental Health for its approval. Submission to the department constitutes a CMH board's official application for state funds. The mental health code required the state to finance 90 percent of the net cost of community mental health services as limited by the appropriation; the counties being responsible for the remaining 10 percent. CMH boards were also authorized to secure private, federal, and other public funds to support their services.

The code mandated CMH programs to direct services to at least one of five areas:

1. Mental illness
2. Mental retardation
3. Organic brain or other neurological impairment or disease
4. Alcoholism
5. Substance abuse.

A service was defined as any of the following:

1. Prevention, consultation, collaboration, educational, or information service
2. Diagnostic service

3. Emergency service
4. Inpatient service
5. Outpatient service
6. Partial hospitalization
7. Residential, sheltered, or protective care
8. Habilitation or rehabilitation
9. Any other service approved by the department.

(For an updated list of available services, see discussion of revised mental health code, below.)

d) The Revised Mental Health Code: Public Act 290 of 1995.

The 1974 Mental Health Code underwent legislative revision during 1995. Public Act 290 of 1995, which took effect on March 28, 1996, amended the title and 201 sections of the existing code. Some of the revisions relating to community mental health were minor, such as alterations to nomenclature ("community mental health programs" are now "community mental health *services* programs," for example), but others were more substantive.

The revised code provides that a community mental health services program is to be organized as either:

- a county community mental health *agency,* or
- a community mental health *organization,* or
- a community mental health *authority.*

A county community mental health *agency* is an existing community mental health board that does not elect to convert itself into a community mental health organization or authority. A county community mental health agency will continue to be an official county agency and the county or counties that established it will continue to be responsible for developing procedures and policies to govern the agency.

A community mental health *organization* is a joint enterprise which two or more counties may create pursuant to Public Act 7 of 1967 (ex. session), the Urban Cooperation Act. In contrast to county community mental health agencies, community mental health organizations would be legally separate entities from the counties that establish them.

Finally, the board of commissioners of a county or counties that established a county community mental health agency or organization may by resolution convert the agency or organization into a community mental health *authority.* The agency or organization first would have to be certified by the Department of Mental Health (now the Department of Community Health). ("Certification" refers to formal departmental approval of a community mental health services program.) A community mental health authority will be a legally separate entity from the county or counties that establish it.

Of the three community mental health entities authorized by the revised mental health code, community mental health authorities have the greatest latitude and may exercise powers not accorded existing community mental health boards. As is the case with existing community mental health boards, a community mental health authority may:

- Acquire, own, operate, maintain, lease, or sell real or personal property;
- Acquire, construct, maintain, or operate buildings or improvements;
- Make purchases or contracts;
- Accept gifts, grants, or bequests, and determine their use;
- Incur debts, liabilities, or obligations which would not be the debts, liabilities, or obligations of the establishing counties;
- Sue and be sued in its own name;

In addition, a community mental health authority may:

- Create reserve accounts, using state funds, to cover vested employee benefits;
- Develop a different fee schedule for services provided.

However, a community mental health authority is not authorized to levy any kind of tax. Nor is it authorized to issue any type of bond, or financially obligate any unit of government other than itself.

The revised code requires that at least one-third of the membership of a community mental health services governing board be composed of persons who have received community mental health services (primary consumers) or family members, and that, of the one-third, at least two individuals be primary consumers. The code did not previously require a fixed proportion of representation.

The revised code authorizes community mental health services programs to establish demonstration projects, such as the issuance of vouchers to recipients of community mental health services or the creation of revolving funds to assist recipients to acquire or maintain affordable housing.

The 1974 code required the state to pay 90 percent and the counties to pay the remaining 10 percent of the net cost of community mental health programs as limited by the appropriation. The revised code provides that if the level of state funding increases after a community mental health services program becomes an authority, the amount of local matching funds required of the authority cannot exceed the level provided by the community mental health services program during the year in which the authority was established. Local matching funds required of the county or counties that established the authority would be similarly limited.

The revised code also authorizes a community mental health services program to carry forward from one fiscal year to the next up to 5 percent of the state's share of its operating budget. The revised code defines "operating margin" as the "excess of state revenues over state expenditures for a single fiscal year exclusive of capitated payments under a managed care system." The statutory authorization to carry over an operating margin is to expire at the end of three years.

The revised code provides greater flexibility to the CMH entities by permitting them to specify how service priorities are established (giving high priority to those in urgent or emergency care situations). The required services under the new revisions include:

- Crisis stabilization and response, consisting of a 24 hour/7 day crisis emergency service including inpatient or other protective environment for treatment;
- Identification, assessment, and diagnosis;
- Planning, linking, coordinating, follow-up, and monitoring to assist recipients in gaining access to services;
- Recipient rights services;
- Mental health advocacy;
- Prevention

Presently, the 52 CMH boards provide a number of services, including:

- Emergency
- Prevention
- Consultation
- Education
- Information
- Diagnosis
- Assertive community treatment
- Family support
- Integrated employment
- Habilitation/rehabilitation
- Services management
- Respite care
- Psychosocial rehabilitation
- Clubhouses
- Residential services support

These services may be provided in several settings, including:

- Inpatient
- Outpatient
- "Day" programs
- Recipient's home
- Residential

2. The Department of Community Health

On January 31, 1996, Governor Engler signed Executive Order 1996-1 which renamed the Department of Mental Health, calling it the Department of Community Health, then transferred to it the Medicaid program and much of the Department of Public Health, and reorganized numerous other health-related agencies in a massive restructuring.

As a result, community mental health services programs are now officially housed in the "behavioral health" component of the new Department of Community Health.

III. Funding Community Mental Health in Michigan

A. Funding Trends

In Fiscal Year 1974-75, the first full fiscal year after the adoption of the mental health code, total state expenditures for CMH were $37.2 million, or 14.3 percent of total Department of Mental Health expenditures of $260.5 million. For FY96, gross expenditures for the mental health component of the Department of Community Health are estimated at $1,534.9 million, of which CMH represents $917.6 million, or 59.8 percent. CMH, in other words, has risen from one-seventh of the mental health budget to three-fifths in two decades.

Put another way, in FY75, the Department of Mental Health had a total of 13,092 full-time equated positions (FTE). By FY96, the shift from institutional care to community-based care had reduced that by 56 percent to 5,803.

By virtually any measure, therefore, this shift from state institutional care to community-based care represents one of the most significant programmatic transformations in the history of state government.

Although CMH growth was most rapid in its early years, growth in the last decade has been rapid by comparison with most other forms of state spending, although CMH growth has been offset by corresponding declines in institutional spending. **Table 2** shows spending by CMH board from FY87 to FY95. Although growth in state spending for CMH has been erratic (largely because of the timing of boards adopting full-management contracts with the state), state spending grew at an average annual rate of 13.8 percent during that period. Now that all CMH boards are on full-management contracts, growth is likely to be slower and more even. (For a discussion of full-management, see the next section.)

B. Allocating State Funds

1. Contracts: Shared Management and Full Management

With the rise of community-based care, the primary responsibility for providing that care shifted from the State to the CMH boards. This was accomplished in stages. In 1981, the Department of Mental Health began offering CMH boards "shared-management" contracts whereby the CMH boards shared responsibility with the state for planning and coordinating public mental health services. Shortly thereafter, the department began offering "full-management" contracts whereby the entire responsibility for providing public mental health services was shifted to the CMH boards. This movement began in 1981 with four full-management pilot contracts. Although the shift was gradual, all 52 CMH boards now have entered into full-management contracts.

Ironically, the timing of the adoption of full-management status has had a significant effect on the distribution of state dollars to CMH boards. Those CMH boards that aggressively sought early full-management status in response to state policy, have found that their funding position has eroded when compared to those boards that adopted full-management status relatively late in the process. The reason for this is that, as long as a CMH board retained shared-management status, the State retained financial responsibility for the clients in that board's catchment area who were in State facilities. However, when the board adopted full-management status, complete financial responsibility for all clients fell upon the CMH board. Because annual budgetary increases for the state clients tended to be greater than for community programs, those boards that became full-management more recently reaped the benefit of relatively high per client expenditures for those that had previously been the responsibility of the State.

2. Local Entrepreneurship

In an effort to encourage innovation and to reward local initiative, the Department historically has funded requests for special projects from CMH boards which subsequently have become part of the budgets of the respective CMH boards. Some boards

Table 2

State Authorization for Community Mental Health Programs
FY 1986-87 to FY 1994-95
(dollars in thousands)

Local CMH Boards	Date Estab.	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95
Alger-Marquette	1966	$4,822.3	$5,109.0	$5,182.9	$5,411.9	$5,498.7	$6,321.9	$6,650.1	$6,816.8	$6,974.1
Allegan	1970	1,626.2	1,650.9	4,237.9	4,513.6	5,049.2	5,249.9	5,66.4	6,512.4	6,888.4
Antrim-Kalkaska	1975	813.1	1,102.7	1,509.2	1,433.2	2,639.9	2,496.5	2,564.6	2,80.1	2,770.0
AuSable Valley	1976	2,224.0	2,456.5	2,883.8	3,059.7	3,107.1	2,970.1	3,588.8	4,037.9	4,174.2
Barry	1973	995.3	1,186.2	1,078.3	1,132.4	1,108.7	2,476.3	2,723.4	2,732.9	2,606.9
Bay-Arenac	1964	7,984.9	9,294.8	9,680.2	10,074.7	10,143.2	9,786.9	11,563.3	12,146.0	11,448.6
Berrien	1966	8,276.3	9,369.8	9,896.9	10,558.4	11,528.1	11,987.8	11,143.5	11,553.9	11,896.1
Branch	1973	662.4	763.2	661.8	736.2	704.0	3,016.5	2,993.9	3,053.4	3,075.1
Calhoun	1965	8,737.1	9,558.5	10,011.6	10,350.9	11,265.7	11,491.4	10,980.4	11,163.5	11,363.5
Cass	1965	1,053.6	1,092.2	1,078.8	1,131.0	3,279.8	3,565.2	3,071.0	3,087.9	3,354.8
Central Michigan	1974	6,541.2	7,183.9	7,859.7	8,167.5	8,395.1	8,167.0	8,537.9	9,542.6	9,413.4
Clinton Eaton-Ingham	1965	21,730.9	22,557.3	23,586.6	25,304.9	25,423.7	24,686.8	26,594.3	28,554.9	27,565.7
Cooper County	1964	3,884.7	5,245.7	5,245.7	5,252.9	5,894.1	5,988.3	6,365.2	6,498.7	6,512.1
Delta	1973	2,418.5	3,069.0	3,169.0	3,271.1	3,481.8	3,670.8	3,757.2	3,766.6	3,999.1
Detroit-Wayne	1964	69,251.8	73,499.9	225,257.2	248,870.2	259,862.4	264,369.6	290,297.6	301,753.3	301,618.1
Eastern UP	1975	1,245.4	3,038.7	3,115.7	3,337.9	3,530.4	4,150.4	3,681.3	4,220.8	4,505.4
Genesee	1965	23,927.1	26,610.4	28,312.4	32,598.5	36,875.1	32,835.6	35,187.2	38,493.6	42,404.2
Gogebic	1975	1,616.5	1,690.5	1,731.3	1,855.6	2,073.2	2,310.2	2,217.7	2,246.8	2,569.6
Grand Traverse- Leelanau	1973	5,252.5	5,756.2	8,304.2	8,820.4	8,675.5	8,250.8	8,701.3	9,631.8	9,341.6
Gratiot	1967	691.6	741.9	704.0	801.8	779.2	1,811.2	2,018.7	2,336.8	2,059.6
Huron	1967	1,855.2	2,048.7	2,136.5	2,285.6	2,302.0	2,193.8	2,316.2	2,421.7	2,474.9
Ionia	1965	2,401.5	2,826.2	2,934.8	3,053.8	3,185.1	3,182.9	3,505.5	3,344.7	3,565.4
Jackson-Hillsdale	1966	4,396.5	5,134.1	5,226.9	10,714.9	10,991.6	11,337.5	13,910.5	14,452.9	14,5988.2
Kalamazoo	1965	16,676.5	18,097.7	19,093.4	19,641.2	22,895.1	23,494.0	28,581.7	30,785.1	33,219.0
Kent	1966	22,956.4	27,139.8	28,043.4	29,126.6	31,030.1	31,414.7	34,486.7	34,480.2	35,276.7
Lake	1972	196.3	397.5	397.2	501.2	619.8	450.6	1,003.0	1,050.7	1,096.5
Lapeer	1972	1,035.7	3,372.9	3,582.9	3,863.4	4,148.5	3,43.8	4,053.8	4,607.5	3,965.3
Lenawee	1972	4,274.6	4,562.0	4,640.0	5,011.5	5,572.7	5,054.1	5,716.4	6,015.6	6,225.0
Livingston	1966	1,237.9	1,418.0	5,016.2	5,722.0	6,180.6	5,744.5	6,426.8	8,233.1	8,202.3
Luce	1973	418.1	460.5	1,189.6	1,349.9	1,363.4	1,688.5	1,413.7	1,649.9	1,547.9
Macomb[1]	1965	9,595.9	10,504.3	11,875.4	11,688.3	11,932.7	11,601.2	11,804.5	52,022.0	55,394.9
Manistee-Benzie	1972	1,766.7	1,978.5	2,344.3	2,601.4	2,763.5	2,761.8	2,951.8	3,296.3	3,273.2
Mason	1966	1,820.8	2,142.0	2,571.0	2,729.1	2,835.0	2,473.7	2,811.9	2,773.1	2,885.5
Midland-Gladwin	1965	3,579.6	4,322.3	4,607.3	4,952.4	5,053.2	4,961.6	5,359.7	6,160.5	6,310.2
Monroe	1965	3,354.6	7,336.2	7,967.0	9,464.2	10,303.9	10,458.2	10,806.6	11,062.4	11,235.5
Montcalm	1965	1,60.9	1,726.2	1,945.7	2,052.5	2,085.9	2,153.7	2,239.8	2,498.1	2,552.9
Muskegon	1966	11,342.2	14,515.4	14,506.4	14,734.6	15,880.6	17,870.2	18,054.9	18,630.5	18,234.8
Newaygo	1972	1,997.1	2,257.2	2,384.6	2,538.4	2,614.7	2,137.5	2,237.2	2,315.2	2,304.9
North Central MI	1973	2,765.4	4,241.5	5,251.0	5,126.0	5,003.0	4,874.6	5,267.9	6,428.6	6,542.1
Northeast MI	1969	2,345.3	2,630.2	3,190.3	3,228.5	3,897.2	4,142.8	4,402.2	4,967.4	6,745.3
Northern MI	1972	1,954.0	2,241.3	3,064.6	5,635.1	5,813.1	5,543.7	6,006.2	6,717.6	6,477.7
Northpointe	1994	3,857.3	4,336.6	4,411.0	5,587.3	5,734.5	6,041.6	6,233.6	6,369.1	6,749.1
Oakland[1]	1964	16,384.2	17,709.7	17,948.8	19,223.1	18,524.1	17,374.9	18,238.0	86,186.0	90,177.8
Oceana	1972	613.3	653.9	936.0	1,032.5	2,342.4	2,021.5	2,037.5	2,102.0	2,077.6
Ottawa	1967	5,922.1	6,517.5	6,833.7	7,894.8	8,104.9	8,414.1	9,197.7	9,028.3	9,573.3
St. Clair	1966	11,681.4	11,803.4	12,167.2	12,798.5	13,030.5	12,486.3	13,215.1	14,279.2	14,652.6
St. Joseph	1969	1,171.4	3,057.7	3,438.0	3,608.8	4,064.9	4,140.2	3,955.2	4,109.8	4,283.4
Saginaw	1966	4,509.1	4,806.5	5,463.4	14,313.8	15,129.1	14,723.6	16,552.1	18,728.6	18,616.9
Sanilac	1971	877.4	1,096.7	1,150.3	1,233.0	1,182.6	2,499.4	2,814.6	3,168.5	2,940.7
Schoolcraft	1973	532.5	657.7	1,106.9	1,187.2	1,135.3	1,423.6	1,512.2	1,378.1	1,434.3
Shiawassee	1964	1,253.5	1,439.9	3,457.1	4,360.0	4,391.7	4,017.8	4,513.8	5,066.9	4,361.4
Tuscola	1972	1,112.8	1,263.6	1,279.0	1,361.9	1,313.7	1,812.1	4,442.9	5,387.1	5,760.1
Van Buren	1970	3,599.0	4,051.5	4,273.0	4,533.6	4,869.2	4,601.2	4,653.4	4,746.1	5,010.0
Washtenaw	1965	12,582.2	14,652.5	15,345.0	16,570.5	18,200.6	17,090.7	18,020.6	18,625.0	19,383.0
TOTAL		$335,422	$382,377	$562,292	$626,686	$663,811	$669,274	$727,247	$874,098	$891,689

[1] These Boards are the last boards to become full management which means they have responsibility for all mental health services in their catchment area. They became full management during FY 1992-93.

Notes: Amendments to contracts may be requested by Community Mental Health boards when an increased authorization is approved. Table represents contract authorizations as of August of the respective contract year.

Source: Michigan Department of Mental Health, Office of Budget Development, Senate Fiscal Agency

have been more aggressive in seeking these funds, and this has contributed to the disparities in funding among the boards.

3. Availability of Local Match.

County matching funds have not always been forthcoming to support CMH. Some boards have been forced to return state funds because the requisite local matching dollars were not provided by their counties.

4. Base Budget for Community Services.

The State has followed an incremental funding policy—what a CMH board has received in any given year has tended to be a percentage increase (or in some cases a decrease). It is not much of a distortion to conclude that the amount a CMH board received in 1996 was dependent as much as anything on what it received fifteen years previously. Thus, any disparities existing several years ago have often been continued and, with the growth of the budget, magnified with the passage of time.

5. The Distribution Process.

Figure 2 indicates the various components making up the state funding amount for a CMH board. Note that the total is arrived at by taking "projected gross funding" and adjusting that figure according to other available sources of funding to arrive at a state total. Projected gross funding is an incremental total that conditions the final amount that will be received from the state.

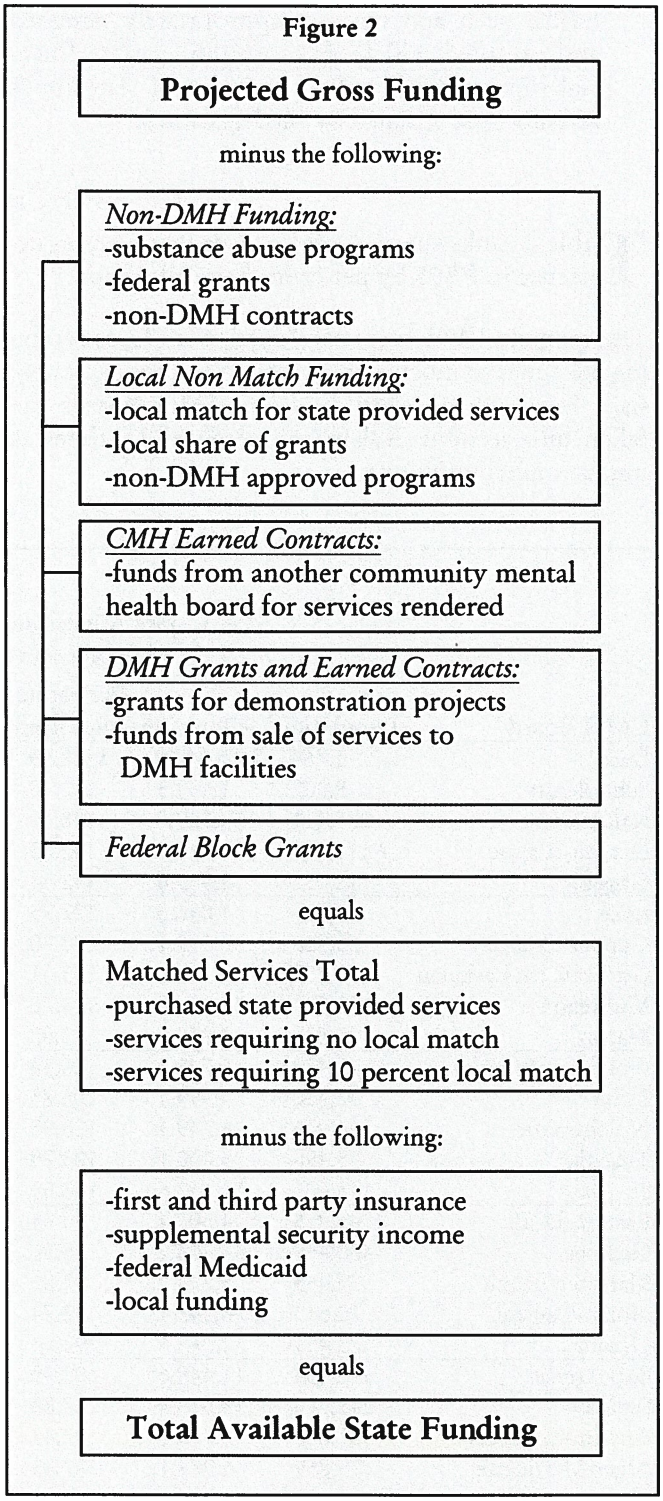
It is unnecessary to describe this chart in detail. The principal reason for displaying it at this point is to show that the funding received by a CMH board comes from a reasonably complex mixture of state, local, federal, and non-governmental sources.

6. CMH Contracts.

State allocations to CMH boards are made under the authority of annual contracts with the Department of Community Health. In considering whether to approve the contract proposed by the CMH board, the revised mental health code requires the Department to consider

- The state's mental health needs;
- The annual plan and needs assessment of the CMH program;

Figure 2



- The state's need for a reasonable degree of statewide standardization and control of services;
- The CMH program's need for a reasonable expectation that services meeting an essential mental

health need and that are appropriately designed and executed will receive continuing state financial support within the constraint of state funds actually appropriated by the legislature;

- The demonstrated relevancy, quality, effectiveness, and efficiency of the CMH program's services;
- The adequacy of the CMH program's accounting for the expenditure of state funds.

C. Per Capita Distribution.

Table 3 ranks the 54 CMH boards that were in existence in FY95 by per capita state allocation.

The range in FY95 was very broad, with Luce receiving 5.6 times as much as Montcalm on a per capita basis. Even when relatively large CMH boards are taken into account, Kalamazoo received 2.9 times as much as nearby Ottawa.

This disparity does not mean that those CMH boards that may be receiving relatively greater amounts of funding than others do not use the resources to good purpose. It simply means that they may be able to serve a different range of clients than other boards are able to serve, or to serve their clients more intensively.

Table 3

Per Capita Allocation, CMH Boards, FY 1994-95
(Allocation in thousands of dollars)

CMH Board	Population	Allocation	Per capita Allocation
Luce	5,763	$ 1,547.9	$268.59
Schoolcraft	8,302	1,434.3	172.77
Kalamazoo	223,411	33,219.0	148.69
Detroit-Wayne	2,111,687	301,618.1	142.83
Gogebic	18,052	2,569.6	142.34
Lake	8,583	1,096.5	127.75
Copper Country	53,955	6,512.1	120.70
Gd Traverse-Leelanau	80,800	9,341.6	115.61
Muskegon	158,983	18,234.8	114.70
Mason	25,537	2,885.5	111.82
Northeast Michigan	63,429	6,745.3	106.34
Delta	37,780	3,999.1	105.85
Northpointe	64,926	6,749.1	103.95
Tuscola	55,498	5,760.1	103.79
St. Clair	145,607	14,652.6	100.63
Eastern U. P.	45,278	4,505.4	99.51
Genesee	430,459	42,404.2	98.51
Manistee-Benzie	33,465	3,273.2	97.81
North Central	70,543	6,542.1	92.74
Oceana	22,454	2,077.6	92.53
Bay-Arenac	126,654	11,448.6	90.39
Saginaw	211,946	18,616.9	87.84
Antrim-Kalkaska	31,682	2,770.0	87.43
Alger-Marquette	79,859	6,974.1	87.33
Monroe	133,600	11,235.5	84.10
Calhoun	135,982	11,365.5	83.57
Oakland	1,083,592	90,177.8	83.22
Macomb	717,400	55,394.9	77.22
Allegan	90,509	6,888.4	76.11
Jackson-Hillsdale	193,187	14,598.2	75.57
Northern Michigan	85,863	6,477.7	75.44
Branch	41,502	3,075.1	74.10
Shiawassee	58,913	4,361.4	74.03
Berrien	161,378	11,896.1	73.72
Sanilac	39,928	2,940.7	73.65
AuSable Valley	56,732	4,174.2	73.58
Van Buren	70,060	5,010.0	71.51
Livingston	115,645	8,202.3	70.93
Huron	34,951	2,474.9	70.81
Kent	500,631	35,276.7	70.46
Central Michigan	137,030	9,413.4	68.70
Washtenaw	282,937	19,383.0	68.51
Lenawee	91,476	6,225.0	68.05
Cass	49,477	3,354.8	67.81
Midland-Gladwin	97,547	6,310.2	64.69
Clinton-Eaton-Ingham	432,674	27,565.7	63.71
Ionia	57,024	3,565.4	62.52
St. Joseph	69,770	4,283.4	61.39
Newaygo	38,202	2,304.9	60.33
Lapeer	74,768	3,965.3	53.03
Gratiot	38,982	2,059.6	52.83
Barry	50,057	2,606.9	52.08
Ottawa	187,768	9,573.3	50.98
Montcalm	53,059	2,552.9	48.11
State Average	9,295,297	$891,689.	$95.93

Source: Senate Fiscal Agency.

IV. Equitable Funding and Managed Care

Theoretically, any of a range of approaches to the distribution of CMH dollars could be adopted. In distributing CMH funds, however, it is difficult to find a better conceptual base on which to build a different approach than that of *need.* If need does not form the basis of the distribution, the conclusion must be that at least some dollars are being directed to programs and services in which the need is less than elsewhere, a difficult position to defend.

If nothing else were known about the need for CMH services, a straight per capita distribution would be, on its face, the most equitable way to distribute CMH resources. This, however, assumes a uniform distribution of those in need of services and it is known that such need is, in fact, not uniformly distributed. It is, therefore, very desirable to adjust a per capita distribution to reflect differences in the prevalence of need for services. The problem is compounded by the fact that CMH services are provided to three groups—1) Mentally Ill - Adult, 2) Mentally Ill - Children, and 3) Developmentally Disabled/Mentally Retarded. The problem is that of finding objective measures of need.

Particularly desirable is finding a measure of need that is derived from data independent of the CMH boards themselves. Data produced by the CMH boards have been inconsistent and, if a distribution formula is to equitably distribute state resources, the data must be consistent. As a consequence, a formula based on data from sources independent of the boards is preferable. If CMH-produced data are to be used, a thoroughgoing audit program that would involve significant costs in training and supervision must be instituted by the Department to assure the validity and comparability of the data and the integrity of the formula.

In addition to reflecting need, a funding formula should support the managed care approach now being adopted for mental health and which is based in large measure on Medicaid funding arrangements.

Two approaches to a needs-based formula for distributing CMH dollars exist. First, needs can be determined by estimating the levels of mental disorder and developmental disability. Since direct measurement is difficult, estimates based on studies of incidences by demographic group could be used. The Department has chosen a method based on incidence of serious mental disorder (described later) as a portion of the measurement of need in the new formula.

Second, needs can be determined by using proxy measures intended to estimate the size of the target population in each CMH catchment area. Although there are several possible measures available, the Department has chosen a combination of the number of Medicaid recipients and an estimate of the number of those without medical care insurance. **Table 4** indicates the impact of using these indicators in distributing CMH dollars.

A. Managed Care

In an attempt to control escalating Medicaid expenditures, improve access, and assure quality care, there has been an increasing emphasis in recent years on placing more Medicaid recipients in managed care programs. Between FY90 and FY96, the total number of Medicaid recipients enrolled in managed care programs increased by 238 percent from 238,653 to 807,069.

1. Managed Care Programs in Michigan.

Three types of managed care programs are currently being used for Medicaid recipients in Michigan: Health maintenance organizations (HMOs), Physician sponsored plans (PSPs), and clinic plans.

The majority of Medicaid recipients (58.2 percent) are enrolled in *physician sponsored plans.* In a PSP, a Medicaid recipient is assigned a single provider (primary care physician), often referred to as a "gatekeeper," who is responsible for locating, monitoring, and coordinating all health care services for the recipient. Health care providers in PSPs are reimbursed on a fee-for-service basis. In addition, primary care physicians receive a monthly management fee ($3.00) for each Medicaid recipient.

Though similar in most respects to PSPs, *health maintenance organizations* are reimbursed on the basis of a fixed, or capitated, annual premium rather than on a

fee-for-service basis. With this arrangement, the HMO assumes the risk that its expenses in providing care will not be covered by the premium, thus encouraging efficiency in the provision of care to Medicaid recipients. In most cases, the choice of providers in an HMO is limited to the HMO's network of physicians and hospitals.

Like HMOs, *clinic plans* provide and approve all health care services for a capitated premium, but are not at risk for inpatient hospital services, which continue to be paid on a fee-for-service basis.

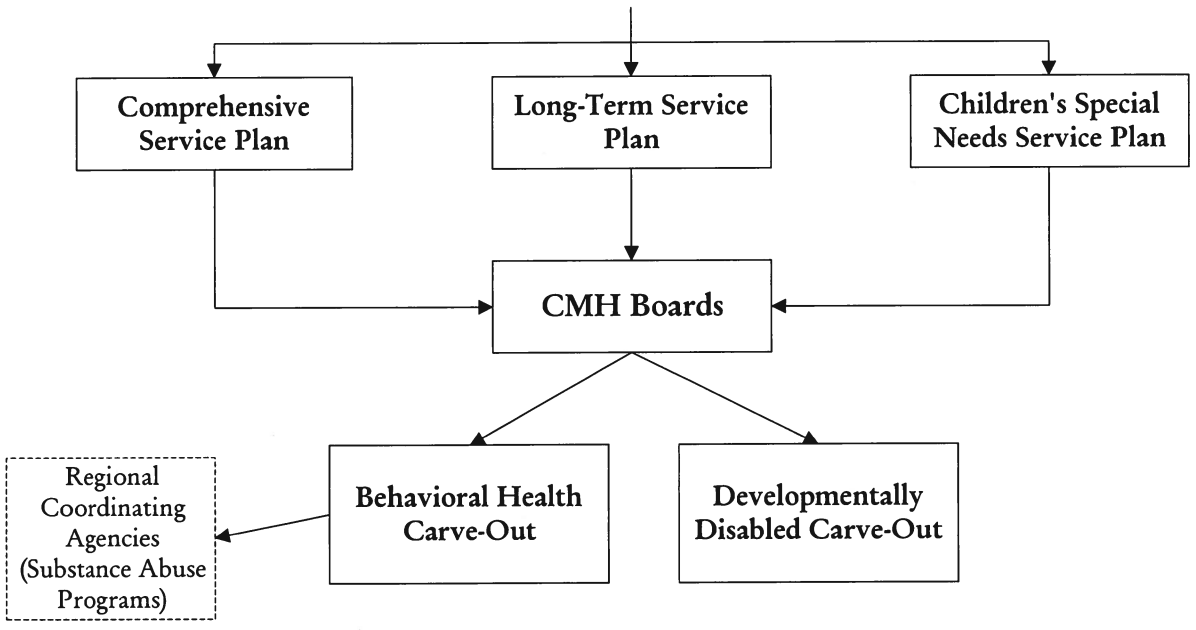
2. Current Plans for Managed Care.

The long-term growth in state Medicaid expenditures, combined with recent Congressional initiatives to restructure the Medicaid program by placing limitations on the growth in federal support, has resulted in plans for a new Medicaid managed care program in Michigan. At the center of this plan is a more expansive managed care program that will place most, if not all, Medicaid recipients in a capitated, risk-based plan (HMO).

As **Figure 3** illustrates, Medicaid recipients in Michigan will enter into one of three managed care service plans: 1) a long-term care service plan for the elderly and disabled; 2) a service plan for children with special health care needs; and 3) a comprehensive service plan for the majority of recipients. Services for Medicaid recipients with mental illness, substance abuse problems, and developmental disabilities will be provided through two service "carve-outs," including a behavioral health carve-out for those with mental health and substance abuse needs and a carve-out for those with developmental disabilities. CMH boards will be responsible for managing services for Medicaid recipients in the appropriate service carve-out.

Although the comprehensive plan will cover only Medicaid recipients, the behavioral health and developmental disability carve outs will cover both Medicaid eligible and non-Medicaid eligible individuals and will not be limited to the provision of services covered by Medicaid.

Figure 3
Medicaid Managed Care Program



Source: Michigan Department of Community Health.

3. Medicaid Managed Care for Mental Health Services.

Planning for and transition to the new Medicaid managed care program is largely dependent on several federal waivers being sought by the state, which would permit it to implement the new program. Assuming the waivers are granted, the state anticipates a full implementation of the new Medicaid managed care program by FY98. The transition to managed care for Medicaid recipients receiving mental health services, substance abuse services, developmental disability services, and most other services is to take place in three phases:

a) Phase I.

(1) Behavioral Health Carve-Out.

Medicaid services and funding for persons with mental illness will be treated as a service "carve out" and will be managed exclusively by the Department of Community Health/Community Mental Health (DCH/CMH) system. Medicaid recipients requiring these services would be referred from one of the three plans to CMH programs. Currently, most specialized mental health services, including those for serious and severe mental disorder and emotional disturbances, are already being provided by the system. Therefore, the principal changes in this phase of the transition would involve DCH/CMH assuming additional responsibilities in the areas of non-state operated psychiatric inpatient services and partial hospitalization services. With this plan, the DCH/CMH system would assume full utilization and fiscal management responsibility for these services and expenditures.

(2) Developmentally Disabled Carve-Out.

Services for Medicaid recipients with developmental disabilities will also be carved out of the comprehensive plan and managed by CMH boards under contract with the Department of Community Health. Since capitated, risk-based contracts are not planned for Medicaid recipients in this phase, a fee-for-service approach will be employed.

b) Phase II.

(1) Behavioral Health.

Capitated contracts for Medicaid recipients with mental illness, as well as enrolled Medicaid recipients, will be executed in the second phase. With the exception of a minimal outpatient benefit and pharmacy and laboratory services, which will remain with HMOs, behavioral health services will be fully "carved out" and managed by the CMH system. Furthermore, while substance abuse funding will be integrated functionally, but not organizationally, with behavioral health in this phase, CMH boards are not expected to necessarily be the managers for all substance abuse services, but are encouraged to develop collaborative arrangements with existing regional coordinating agencies.

(2) Developmentally Disabled Carve-Out.

In the second phase, services to Medicaid recipients with developmental disabilities will continue to be treated as a service carve-out and managed by CMH programs under capitated contracts.

(3) CMH Contracts.

DCH will define various administrative and service criteria which must be met by CMH programs in order to qualify for contracts with DCH for the management of the service carve outs. The criteria encourage the formation of mergers, consortiums, and other partnerships, so that the CMH system can fulfill administrative requirements under the contract and manage utilization and expenditure risk.

c) Phase III.

The third and final phase of the transition to Medicaid managed care for the behavioral health and developmental disability carve outs involves the implementation of a full-blown bidding process. Both CMH programs and other health care providers will be eligible to bid. However, all bidders will be required to meet the same provider standards for organizational capacity, quality care, consumer involvement, and cost effectiveness.

Under this plan, the future of CMH boards will depend upon their success in the bidding process. Essentially, CMH boards will be subjected to competition in the delivery of services and it is clear that a substantial prospect exists for privatizing the delivery of CMH services in many parts of the state. In some areas, CMH boards remain the only available source of services and serious competition may not immediately come forth. In others, however, competition is likely to be intense and could substantially alter the way in which CMH services are delivered.

B. Allocating Dollars in Fiscal Year 1996-97.

The distribution of CMH dollars in Fiscal Year 1996-97 reflects the continuing concern for achieving equity in CMH funding (discussed elsewhere), the desire to develop an appropriate means of supporting managed care, and the necessity of dealing with a funding problem requiring reductions in the authorizations to Community Mental Health Service Programs (CMHSPs).

The funding problem is the result of the timing of the contractual authorization of dollars to CMHSPs related to facility reduction. An estimate is made in one fiscal year as to the amount of reduction in the population of state facilities. This, in turn, forms the basis for the appropriation request to the legislature. If the actual population reduction is greater, or the facility budget falls short of the appropriated amount and a greater transfer to the CMHSP is required in order to fulfill the contractual agreement, funds must be found elsewhere, or expenditures must be reduced.

Prior to the 1995 mental health code revisions, such shortfalls could be covered by lapses (unused appropriation authority) in other areas of the CMH budget. The revised code, however, provides for retention of lapses by the CMHSPs, thereby foreclosing this approach in the future.

For FY97, there is a $35 million difference between the legislative appropriation and the contractual obligation to the CMHSPs. DCH has adopted a strategy to deal with this that includes a reduction of $20 million in state Medicaid funds for inpatient psychiatric expenditures and a net reduction in distributions to CMHSPs of $15.0 million.

Rather than employ an across-the-board reduction of $15.0 million, DCH will use the shortfall as an opportunity to begin to move toward a more equitable distribution based on a three-factor formula consisting of 1) Medicaid recipients; 2) Uninsured population; and 3) Prevalence of severe mental disorder.

1. The New Distribution Formula.

The three factors in the distribution formula for FY97 are:

1) *Medicaid Recipients* (Approximately 25 percent): Persons eligible for Medicaid as of December 1995, including the categories of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and Medically Needy.

2) *Uninsured* (Approximately 25 percent): Estimates of the number of the number of individuals not covered by health insurance were based on a 1995 update of a 1988 survey conducted in Michigan and reported in the report of the Governor's Task Force on Access to Health Care. The update appeared in *Health Policy Update* (July 1995, Issue XV, Michigan Department of Public Health) and projected the 1988 figures forward to 1991 based on county by county changes in age, race, educational attainment, industrial affiliation, and poverty.

3) *Serious Mental Disorder* (50 percent): The most complex calculations built into the formula involve estimation of the level of serious mental disorder (SMD) by CMH catchment area.

This component of the formula is based on an approach developed by David Jarjoura, et al, for distributing CMH funds in Ohio. ("Synthetic Estimation of the Distribution of Mentally Disabled Adults for Allocations to Ohio's Mental Health Board Areas." *Evaluation and Program Planning*, Vol. 16, 1993.)

In this approach, epidemiological catchment area (ECA) data on the prevalenced of adult SMD were obtained from a study done under the auspices of the National Institute of Mental Health (NIMH). These prevalences were then applied to a board area's demographic mix to yield the estimated SMD count. The demographic variables include age, race, sex, education, and marital status. The prevalence estimates appear in **Table 4**.

The basic approach is to apply these prevalences to the demographic makeup of each CMH catchment area and, with the resulting estimates, determine the proportion of total statewide SMD represented in each catchment area.

A complicating factor in this approach is that the requisite census data are available only by Public Use Micro Areas (PUMAs) and not by county or CMH catchment area. For boards containing a total of 72 percent of Michigan's population, this does not consti-

tute a problem. There are 16 single-county PUMAs that are coterminous with CMHSPs. In addition, one CMHSP consists of one single-county PUMA and one 2-county PUMA. For these 17 CMHSPs, the SMD prevalence estimates of the PUMAs are directly applicable. The remaining 35 boards, with 28 percent of total Michigan population, are in multi-county PUMAs.

The range of available census demographic data is not as extensive for counties as it is for PUMAs. As a result, it became necessary to allot SMD prevalence estimates of each multi-county PUMA to its constituent counties and then to assemble these county prevalence estimates by CMH board area. In doing so, marital status and education (which are components of the Jarjoura estimates and which are reported by county) were used in making these adjustments.

Combining the Factors. In order to capture both economic need and need for mental health services the three factors were weighted (50 percent for Medicaid and the uninsured and 50 percent for SMD) and added together. The resulting total for each CMHSP was made a proportion of the total for the state to determine the appropriate allocation.

Table 4

Estimated SMD Prevalences By Five Demographic Variables

			Married		Sep/Wid/Div		Single	
Age	Sex	Race	HS-	HS+	HS-	HS+	HS-	HS+
18-24	Male	Wh+Other	.00522	.00282	.02116	.01049	.02211	.00432
18-24	Male	Black	.00857	.00441	.03134	.01484	.03690	.00693
18-24	Male	Hispanic	.00174	.00070	.00446	.00163	.00419	.00060
18-24	Female	Wh+Other	.01283	.00762	.05106	.02808	.05113	.01120
18-24	Female	Black	.03505	.01996	.12021	.06512	.13414	.02999
18-24	Female	Hispanic	.01371	.00608	.03460	.01414	.03123	.00502
25-44	Male	Wh+Other	.01736	.00620	.09809	.03374	.10818	.01501
25-44	Male	Black	.00915	.00309	.04912	.01550	.06123	.00772
25-44	Male	Hispanic	.00615	.00163	.02320	.00565	.02324	.00222
25-44	Female	Wh+Other	.03017	.01189	.16146	.06341	.17064	.02752
25-44	Female	Black	.02684	.01003	.13429	.04924	.15794	.02392
25-44	Female	Hispanic	.03387	.01000	.11908	.03420	.11477	.01312
45-64	Male	Wh+Other	.02471	.01426	.09052	.03907	.09623	.01674
45-64	Male	Black	.02353	.01017	.07921	.03229	.09438	.01557
45-64	Male	Hispanic	.02453	.00835	.05799	.01839	.05584	.00700
45-64	Female	Wh+Other	.01314	.00651	.04997	.02299	.05112	.00935
45-64	Female	Black	.02104	.00994	.07160	.03172	.08211	.01465
45-64	Female	Hispanic	.04076	.01534	.09468	.03369	.08777	.01240
65+	Male	Wh+Other	.00634	.00212	.02199	.00676	.02125	.00256
65+	Male	Black	.02178	.00699	.06657	.02008	.07232	.00869
65+	Male	Hispanic	.00728	.00181	.01585	.00362	.01377	.00123
65+	Female	Wh+Other	.00116	.00152	.01460	.00189	.01351	.00177
65+	Female	Black	.02416	.00850	.07382	.02447	.07699	.01017
65+	Female	Hispanic	.01521	.00418	.03298	.00835	.02753	.00273

Source: Jarjoura, et al. (See text)

Table 5 indicates the effect of applying these factors to the funding levels for 1995-96. The impact in certain cases is significant and demonstrates the extent to which the previous distribution of funding had departed from needs-based allocation. The table indicates that allocation adjustments ranging from a decrease of 53.7 percent to an increase of 148.5 percent would be required to place each CMHSP at the state average.

In order to minimize the short-term disruption that would occur if the formula were applied fully, the formula will affect only those CMHSPs that are currently overfunded and those that are underfunded to the extent that their allocations would have to be increased by 110 percent or more. In doing this, the $15 million in savings is to be accomplished by a reduction of $16.1 million apportioned among the 14 CMHSPs that are overfunded, with $1.1 million redistributed to the four most underfunded CMHSPs, for a net reduction of $15.0 million. The two columns on the far right in the table indicate the actual effect of this modified application of the formula. At least for FY97, the formula would have no impact on 34 CMHSPs.

Future Adjustments to the Formula. Once need is established as the basis for funding distribution, adjustments to the basic approach can be made. Three kinds of adjustments might be appropriate.

First, the formula does not take developmental disability prevalences into account. The existing data do not provide for a method of estimating DD prevalence. It is likely, however, that in the development of managed care for DD, adjustments will be made that will result in more equitable distribution of DD dollars.

Second, additional factors may be added to further refine the existing measure of SMD. For example, NIMH is funding a study of the prevalence of SMD among children that might be incorporated into the formula at some point in the future to make funding for children with mental illness more responsive.

Finally, the formula could be expanded to bring more CMHSPs closer to the state average. This could be phased in to accommodate changes in the funding level for community mental health in coming years.

Table 5

Impact of Funding Formula Change on Distribution of CMH Funds

CMH Board Name	(1) Total 1994 Population in Board Area	(2) Total Medicaid Population	(3) Medicaid Population as percent of Total Population	(4) Uninsured Population	(5) Uninsured Population as percent of Total Population	(6) Sum of Medicaid & Uninsured Populations	(7) Sum as as percent of Total Population	(8) FY95/96 Adjusted State Funding
Superior Behavioral (Luce)	5,571	1,294	23.23	500	8.98	1,794	32.20	$ 682,489
Grand Traverse/Leelanau	87,705	6,862	7.82	8,600	9.81	15,462	17.63	5,594,599
Kalamazoo County	228,798	22,410	9.79	15,600	6.82	38,010	16.61	14,858,337
Schoolcraft County	8,596	1,495	17.39	800	9.31	2,295	26.70	609,600
Gogebic County	18,016	2,517	13.97	1,600	8.88	4,117	22.85	1,036,065
Copper County	54,990	7,057	12.83	4,900	8.91	11,957	21.74	3,407,884
Detroit-Wayne	2,064,819	418,021	20.24	196,400	9.51	614,421	29.76	159,242,602
Oakland County	1,142,013	65,830	5.76	93,200	8.16	159,030	13.93	47,843,861
Macomb County	728,902	40,779	5.59	61,700	8.46	102,479	14.06	30,142,566
Livingston County	129,083	4,586	3.55	9,800	7.59	14,386	11.14	4,275,154
Delta County	38,606	5,057	13.10	3,400	8.81	8,457	21.91	1,869,351
Northpointe Behavioral	64,723	6,643	10.26	5,700	8.81	12,343	19.07	2,608,418
St. Joseph County	60,000	6,188	10.31	4,200	7.00	10,388	17.31	2,308,609
Antrim-Kalkaska	34,065	4,151	12.19	3,400	9.98	7,551	22.17	1,532,446
Mason-Lake-Oceana	60,324	9,883	16.38	6,300	10.44	16,183	26.83	2,990,022
Alger-Marquette	80,503	6,819	8.47	7,200	8.94	14,019	17.41	3,055,000
St. Clair County	152,413	14,405	9.45	19,700	12.93	34,105	22.38	6,820,838
Muskegon County	163,436	25,759	15.76	11,400	6.98	37,159	22.74	7,370,009
Washtenaw County	290,546	17,773	6.12	24,900	8.57	42,673	14.69	9,535,009
Calhoun County	139,991	20,703	14.79	9,700	6.93	30,403	21.72	5,882,760
Kent County	520,129	48,614	9.35	35,000	6.73	83,614	16.08	17,533,377
Berrien County	161,734	24,013	14.85	11,500	7.11	35,513	21.96	6,826,391
Bay-Arenac	127,727	16,177	12.67	16,800	13.15	32,977	25.82	5,652,765
Monroe County	137,718	11,111	8.07	12,000	8.71	23,111	16.78	4,789,808
Branch County	41,990	4,889	11.64	2,900	6.91	7,789	18.55	1,460,211
Northern Michigan	92,442	10,235	11.07	9,200	9.95	19,435	21.02	3,437,738
Woodland Behavioral (Cass)	48,921	5,866	11.99	3,600	7.36	9,466	19.35	1,847,707
Jackson-Hillsdale	198,119	22,377	11.29	17,200	8.68	39,577	19.98	7,311,005
Manistee-Benzie	35,897	4,870	13.57	3,700	10.31	8,570	23.87	1,377,436
Eastern UP	47,501	5,246	11.04	4,300	9.05	9,546	20.10	1,725,012
North Central	76,731	12,059	15.72	7,600	9.90	19,659	25.62	2,856,420
Genesee County	433,297	74,654	17.23	61,100	14.10	135,754	31.33	19,023,156
VanBuren County	73,848	11,026	14.93	5,000	6.77	16,026	21.70	2,534,361
Northeast Michigan	64,744	8,747	13.51	6,900	10.66	15,647	24.17	2,299,202
Barry County	52,232	3,989	7.64	3,400	6.51	7,389	14.15	1,293,077
Tuscola County	57,018	6,270	11.00	7,700	13.50	13,970	24.50	1,749,650
Ottawa County	205,338	8,830	4.30	13,000	6.33	21,830	10.63	3,801,549
Lenawee County	95,669	8,955	9.36	8,200	8.57	17,155	17.93	2,380,211
Clinton-Eaton-Ingham	436,130	43,242	9.91	60,100	13.78	103,342	23.70	12,270,413
Allegan County	96,087	6,813	7.09	6,200	6.45	13,013	13.54	2,099,262
AuSable Valley	52,779	8,492	16.09	6,100	11.56	14,592	27.65	1,623,373
Saginaw County	211,287	36,416	17.24	30,100	14.25	66,516	31.48	7,188,733
Huron Behavioral	35,215	4,152	11.79	5,100	14.48	9,252	26.27	1,038,000
Newaygo County	42,739	5,816	13.61	4,100	9.59	9,916	23.20	1,222,010
Central Michigan	144,641	20,084	13.89	15,000	10.37	35,084	24.26	3,908,850
Lapeer County	81,242	5,534	6.81	10,500	12.92	16,034	19.74	1,645,978
Shiawassee County	71,645	7,138	9.96	9,600	13.40	16,738	23.36	1,583,769
Sanilac County	41,568	4,739	11.40	5,800	13.95	10,539	25.35	971,831
Ionia County	59,194	5,257	8.88	8,100	13.68	13,357	22.56	1,262,189
Midland-Gladwin	103,185	11,052	10.71	12,200	11.82	23,252	22.53	1,937,259
Gratiot County	39,785	5,013	12.60	5,400	13.57	10,413	26.17	774,801
Montcalm Center	56,887	6,964	12.24	7,500	13.18	14,464	25.43	1,122,491
Total	9,496,539	1,146,872	12.08	903,900	9.52	2,050,772	21.59	$438,213,654

Explanation of Table: Columns 2 and 3 are December 1995 Medicaid population and percentages. Columns 4 and 5 are updated (1991) uninsured populations and percentages. Columns 6 and 7 add the Medicaid and uninsured populations and calculate them as a percentage of total population (Col. 1).

Column 8 is total FY96 state funding reduced to account for the full-year impact of a 1996 change in state facility reimbursement.

Table 5 (continued)

(9) State Funds per Combined Med/Unins Populations	(10) State Funding Based on Med/Unins Populations	(11) SMD Adults	(12) SMD Adults as percent of Total Population	(13) FY95/96 State Funding per SMD	(14) State Funding Based on SMD	(15) 50% Med/ Unins plus 50% SMD	(16) Dollar Change from FY95/96 State Funding	(17) Percent Change	(18) Effect of $16.1 million Reduction & $1.1 million Redirection	(19) Percent Change 50-50
$ 380.43	$ 383,249	79	1.42	$ 8,639	$ 248,636	$ 315,943	$ -366,547	-53.71	$ (110,598)	-16.21
361.83	3,303,119	1,037	1.18	5,395	3,263,739	3,283,429	-2,311,170	-41.31	(697,352)	-12.46
390.91	8,120,007	3,072	1.34	4,837	9,668,474	8,894,241	-5,964,097	-40.14	(1,799,553)	-12.11
265.62	490,277	121	1.41	5,038	380,822	435,550	-174,051	-28.55	(52,516)	-8.61
251.66	879,507	204	1.13	5,079	642,047	760,777	-275,288	-26.57	(83,063)	-8.02
285.01	2,554,352	787	1.43	4,330	2,476,917	2,515,635	-892,250	-26.18	(269,219)	-7.90
259.18	131,257,638	39,472	1.19	4,034	124,229,807	127,743,723	-31,498,880	-19.78	(9,504,190)	-5.97
300.85	33,973,289	14,780	1.29	3,237	46,516,937	40,245,113	-7,598,748	-15.88	(2,292,778)	-4.79
294.13	21,892,402	9,874	1.35	3,053	31,076,336	26,484,369	-3,658,197	-12.14	(1,103,792)	-3.66
297.17	3,073,255	1,434	1.11	2,981	4,513,213	3,793,234	-481,920	-11.27	(145,410)	-3.40
221.04	1,806,653	518	1.34	3,609	1,630,296	1,718,475	-150,877	-8.07	(45,524)	-2.44
211.33	2,636,813	758	1.17	3,441	2,385,645	2,511,229	-97,189	-3.73	(29,325)	-1.12
222.24	2,219,170	753	1.26	3,066	2,369,909	2,294,539	-14,070	-0.61	(4,245)	-0.18
202.95	1,613,106	461	1.35	3,324	1,450,900	1,532,003	-443	-0.03	(134)	-0.01
184.76	3,457,145	812	1.35	3,682	2,555,599	3,006,372	16,350	0.55		
217.92	2,994,853	1,016	1.26	3,007	3,197,646	3,096,250	41,250	1.35		
200.00	7,285,789	2,161	1.42	3,156	6,801,292	7,043,541	222,703	3.27		
198.34	7,938,209	2,383	1.46	3,093	7,499,991	7,719,100	349,091	4.74		
223.44	9,116,155	3,759	1.29	2,537	11,830,661	10,473,408	938,399	9.84		
193.49	6,494,937	2,069	1.48	2,843	6,511,742	6,503,340	620,580	10.55		
209.69	17,862,306	6,839	1.31	2,564	21,524,312	19,693,309	2,159,932	12.32		
192.22	7,586,577	2,487	1.54	2,745	7,827,309	7,706,943	880,552	12.90		
171.42	7,044,816	1,840	1.44	3,072	5,791,012	6,417,914	765,149	13.54		
207.25	4,937,161	1,901	1.38	2,520	5,982,997	5,460,079	670,271	13.99		
187.47	1,663,950	539	1.28	2,709	1,696,389	1,680,169	219,959	15.06		
176.88	4,151,864	1,200	1.30	2,865	3,776,747	3,964,306	526,568	15.32		
195.19	2,022,204	716	1.46	2,581	2,253,459	2,137,832	290,125	15.70		
184.73	8,454,762	2,760	1.39	2,649	8,686,519	8,570,641	1,259,636	17.23		
160.73	1,830,793	482	1.34	2,858	1,516,993	1,673,893	296,457	21.52		
180.71	2,039,295	704	1.48	2,450	2,215,692	2,127,494	402,482	23.33		
145.30	4,199,716	1,036	1.35	2,757	3,260,592	3,730,154	873,734	30.59		
140.13	29,000,880	6,725	1.55	2,829	21,165,521	25,083,201	6,060,045	31.86		
158.14	3,423,605	1,063	1.44	2,384	3,345,569	3,384,587	850,226	33.55		
146.94	3,342,640	896	1.38	2,566	2,819,971	3,081,306	782,104	34.02		
175.00	1,578,499	630	1.21	2,053	1,982,792	1,780,646	487,569	37.71		
125.24	2,984,386	751	1.32	2,330	2,363,614	2,674,000	924,350	52.83		
174.14	4,663,503	2,275	1.11	1,671	7,160,083	5,911,793	2,110,244	55.51		
138.75	3,664,791	1,231	1.29	1,934	3,874,313	3,769,552	1,389,341	58.37		
118.74	22,076,763	5,635	1.29	2,178	17,734,976	19,905,869	7,635,426	62.23		
161.32	2,779,943	1,288	1.34	1,630	4,053,709	3,416,826	1,317,564	62.76		
111.25	3,117,262	713	1.35	2,277	2,244,017	2,680,640	1,057,267	65.13		
108.08	14,209,692	3,170	1.50	2,268	9,976,907	12,093,300	4,904,567	68.23		
112.19	1,976,488	494	1.40	2,101	1,554,761	1,765,624	727,625	70.10		
112.04	2,118,337	535	1.25	2,077	1,683,800	1,901,068	790,058	71.11		
111.41	7,494,931	1,907	1.32	2,050	6,001,881	6,748,406	2,839,556	72.64		
102.66	3,425,314	1,018	1.25	1,617	3,203,941	3,314,627	1,668,649	101.38		
94.62	3,575,708	909	1.27	1,742	2,860,886	3,218,297	1,634,528	103.20		
92.21	2,251,427	555	1.34	1,751	1,746,746	1,999,086	1,027,255	105.70		
94.50	2,853,432	810	1.37	1,558	2,549,304	2,701,368	1,439,179	114.02	50,771	4.02
83.32	4,967,282	1,257	1.22	1,541	3,956,143	4,461,713	2,524,454	130.31	393,469	20.31
74.41	2,224,510	493	1.24	1,572	1,551,614	1,888,062	1,113,261	143.68	260,980	33.68
77.61	3,089,918	791	1.39	1,419	2,489,506	2,789,712	1,667,221	148.53	432,481	38.53
$ 213.68	$ 438,102,680	139,200	1.47	$3,147	$ 438,102,684	$ 438,102,684	-$0-	-0-	$ (15,000,000)	

Columns 9 and 10 calculate the amount of distribution that would occur if funding were based solely on Medicaid and uninsured populations, using the state average rate for these populations.

Columns 11 and 12 display the estimates of adults with serious mental disorder and calculate them as percentages of total population. Column 13 displays the amount of state funding per adult with SMD. Column 14 calculates the effect of basing funding exclusively on SMD proportions.

Column 15 is the operant calculation for the formula and calculates the distribution by weighting Medicaid/uninsured at 50 percent and SMD at 50 percent.

Columns 16 and 17 calculate the change from the actual distribution (Col. 8) in dollar amounts and in percentage change.

Columns 18 and 19 show the effect of the FY97 reduction of $16.1 million in those CMHSPs that are relatively overfunded, with a redirection of $1.1 million to CMHSPs that are the most underfunded, for a net reduction of $15.0 million.

V. Conclusion

Perhaps the single most evident aspect of the provision of mental health services over the past 30 years is change. The shift from institutional care to community-based care that began in the early 1960s represents one of the most significant shifts of funding and organizational responsibility in the history of state government.

Major change continues with the advent of managed care. Managed care introduces an element of uncertainty into public mental health services that may take several years to resolve. The providers, financing, and organizational structure involved in mental health are very likely to look much different at the turn of the century than they do at present. Fewer managing CMH entities, greater privatization of care, and a role for the state as contract manager are probable outcomes of the institution of managed mental health care.

Managing this change will present some formidable challenges that will involve institutional change on the part of the Department of Community Health. For much of its history, the Department was a direct provider of services through the institutions. Its role has evolved in the last 30 years as it has reduced its level of direct service provision and adopted the responsibility of financing locally-provided services. Managed care will accelerate this shift from service provider to purchaser of care and contract manager, and the challenge to the Department will be that of adopting the oversight mechanisms and structures that will permit it to know in a systematic way the extent to which mental health services are accomplishing their intended objectives.

A major part of the new environment will be the way in which funds are allocated to support CMH services. Capitated approaches will require a more equitable distribution than that which has characterized CMH funding in the past. The approach adopted for Fiscal Year 1996-97, based on Medicaid caseloads, uninsured populations, and the prevalence of serious mental disorder represents a step toward both creating greater equity and directing dollars toward those areas of the state in which both the prevalence of mental disorder and economic stress are most severe.

As managed care is implemented it will be necessary to review the allocation of dollars, their relationship to need, and the effectiveness with which they are spent. These are interrelated functions and, with the changes underway, will undergo significant alteration in the next few years.