Innovative Ways to Finance Mental Health Services in a Primary Care Setting

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The State of Michigan has a complex array of Medicaid waivers, administrative organizations and systems involved in the delivery of mental health, substance abuse and physical health care to Medicaid and indigent consumers. In Washtenaw County, Michigan a model has emerged for organizing multiple funding sources to provide effective models of integrated care for the most vulnerable citizens. This White Paper describes each source of funding and how, through the use of existing resources, local collaboration, and public/private partnerships, a seamless system of health care delivery and payment has emerged.

The Michigan, Public Health Care Funding Matrix:

The State of Michigan has five federal Medicaid waivers, three sources of general funds (federal, state, local) and one source of local, indigent physical health care separate from Medicaid. These waivers provide the bulk of the mental health, substance abuse and physical health care funding for individuals who are indigent and/or those who qualify for Medicaid.

Primary Health Care Funding

Comprehensive Health Care Program for Medicaid Eligible Persons: The State of Michigan has a 1915 (b) waiver of Section 1902 (a)(23) that provides for most Medicaid recipients to be enrolled in physical health care plans that operate across the State. Medicaid recipients enrolled in a health plan receive capitated, managed health care services that include a “20 visit” mental health benefit provided by the Health Plans. Specialty mental health services are carved out to the public mental health system. Medicaid Health Plans are responsible for providing preventive, acute and chronic health care for all of their enrollees. In Washtenaw County there are two approved Medicaid Health Plans. The Health Plans are private, for-profit entities.

Indigent Health Plan Funding: In Michigan there is an emerging network of County based indigent health plans funded through an 1115 Waiver that allows the State to use unspent S-CHIP dollars to provide a “Medicaid like” health benefit for individuals at 185% of the federal poverty level. Known as the Adult Benefit Waiver (ABW) these programs provide outpatient, primary and specialty care services for individuals who do not qualify for Medicaid. Washtenaw County’s indigent health plan is known as the Washtenaw Health Plan (WHP). The 1115 Wavier that creates this program includes a mental health and substance abuse benefit that is carved out to the community mental health and substance abuse systems.

The indigent health plans also have access to local money that can be matched to provide similar health plan services to indigent consumers above 185% of poverty.

MiChild: Michigan has an SCHIP program called Mi-Child that provides a Medicaid physical health benefit for individuals under the age of 18. MiChild includes a mental health and substance abuse benefit that is carved out and managed by the public systems in the state.

The combination of these three health plan options (Medicaid, WHP and Mi-Child) provide for a nearly comprehensive set of physical health services for vulnerable adults.

Mental Health and Substance Abuse Funding

As noted above the physical health plan waivers carve out most of the mental health and substance abuse benefits to the public system. The mental health system then has Waivers for those public mental health benefits.

1915 (b) Freedom of Choice Waiver: Michigan's waiver of Section 1915(b) of the Social Security Act provides for fourteen (14) different state plan mental health and substance abuse services and fourteen (14) alternative services that can be used in place of the state plan services. These services are managed by a set of eighteen (18) Prepaid Inpatient Health Plans (PIHP) that are public mental health boards. The twenty eight (28) services are identified in Table 1.

Table 1: 1915 (b) Michigan Waiver Services

State Plan Services	Alternative Services
ICF/MR <16 beds	Prevention and Consultation
Inpatient Psychiatric Services (Adult)	Crisis Response (23 hour beds)
Intensive Crisis Residential	Community Living Training and Supports
Inpatient Psychiatric Service (Under 22 years of age)	Skill Building Assistance
Partial Hospitalization Services	Peer Operated Support Services
Intensive Crisis Stabilization	Wraparound Services of Child/Adolescents
Physician Services (Psychiatric)	Family Skills Development
MH Clinic Services	Respite Care
MH Rehabilitation Services	Housing Assistance
PSR Services	Assistive Technology*
Case Management	Assessment and Evaluation*
EPSDT Related Services	Supports Coordination*
Substance Abuse Rehab Services	Enhanced Health Care Services*
Personal Care In Specialized	Assistance with Challenging

Residential	Behaviors*

*Available for DD consumers only

1915 (c) Habilitation Supports Waiver: This waiver provides for seventeen (17) specialty services for persons with developmental disabilities and is managed by the public mental health system. The services available under this waiver are identified in Table 2.

Table 2: 1915 (c) Michigan Waiver Services

Enhanced pharmacy	Private Duty Nursing
Enhanced Medical Equipment/Supplies	Chore Services
Enhanced dental	PERS
Extended State Plan Services	Habilitation
Supports Coordination	Prevocational Services
Other CLS Services	Environmental Modifications
Respite Care	Day Habilitation
Family Training	Supported Employment
Educational Services	

Adult Benefit Waiver: The Adult Benefit Waiver's mental health and substance abuse services include basic outpatient services for individuals who do not meet serious and persistent mental illness criteria. The Mental Health and Substance Abuse systems also provide specialty mental health services through the public mental health system for persons with a serious and persistent illness who are on the ABW. If ABW funds are not sufficient to fund the entire specialty benefit the CMH's and Substance Abuse Coordinating systems must use general funds to provide those services

Mi-Child: The Mi-Child, SCHIP program also provides for a mental health and substance abuse benefit for individuals under the age of 18. Very similar to the ABW wavier for adults, Mi-Child provides a basic outpatient benefit of non-SED children with the public mental health and substance abuse systems responsible out of general funds for SED children and/or children who don't qualify for Mi-Child.

These Medicaid or Medicaid-like entitlement programs comprise nearly 80% of the funding that is received by Washtenaw County for mental health and substance abuse services. The State has consistently pursued carve out models allowing the public mental health and substance abuse systems to manage a wide range of benefits for a large population of State residents.

In addition to Medicaid and Medicaid-like entitlement programs the local CMH and Substance Abuse systems manage state and local general funds and federal block grant dollars. These funds are more flexible and are meant to provide a

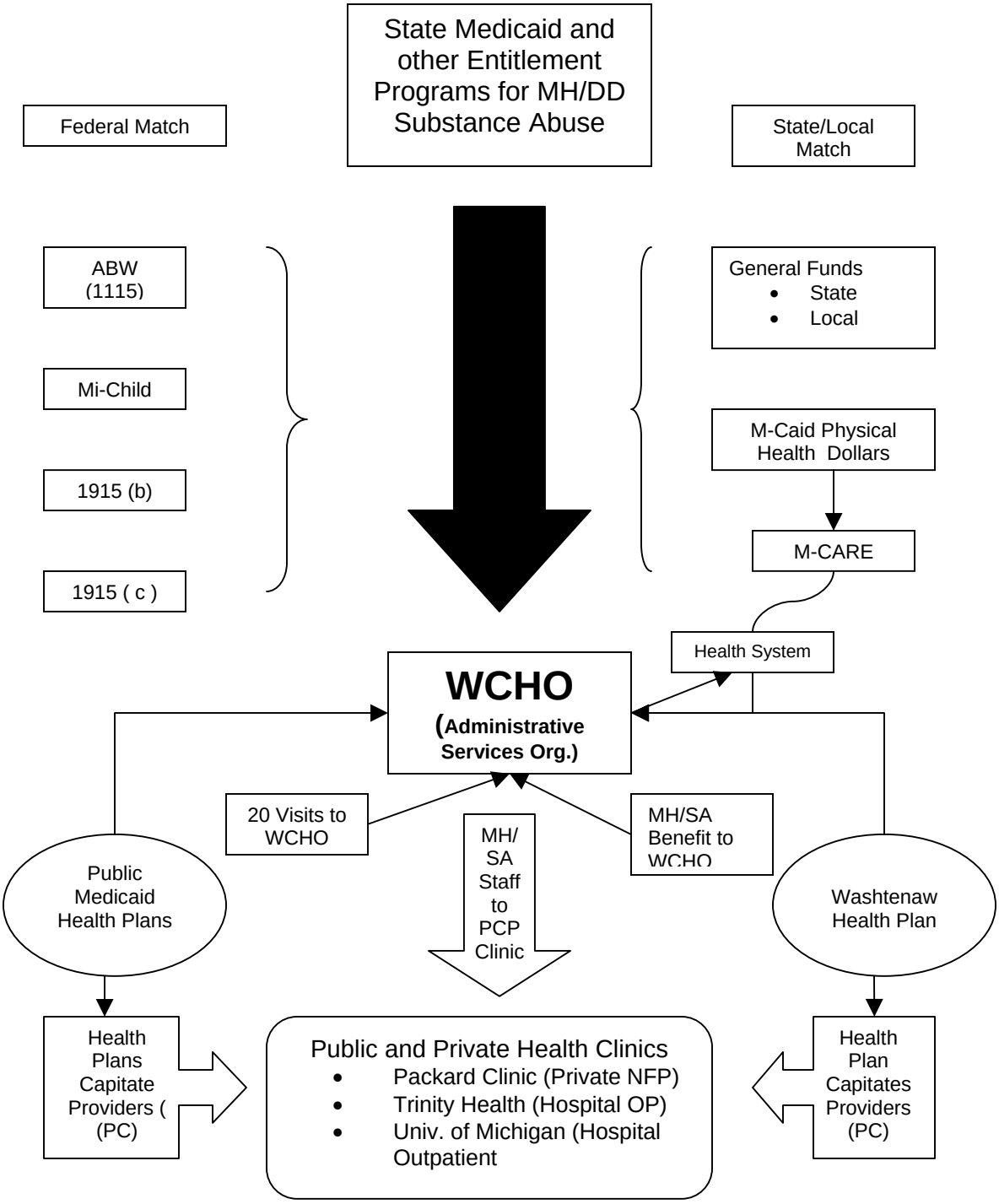
basic mental health and substance abuse benefit for indigent consumers who do not qualify for any of the means-tested entitlement programs. General fund consumers are eligible for a basic outpatient benefit that includes case management/supports coordination, psychiatric services, emergency services and inpatient hospitalization.

Bringing The Bifurcated Funding and Health Policy Setting Together At the Local Level: The Washtenaw Community Health Organization (WCHO)

While the WCHO strongly supports the State's strategy of carving out the behavioral health benefits at the State level, locally the WCHO is committed to providing a seamless, integrated system of health care for its vulnerable citizens. The WCHO believes that all politics and health care is local so that while our system may serve as a model for others, it would not work for all and hence a carve-in model from the State level could actually impede local collaboration if implemented.

For example, if the State were to merge the physical health and behavioral health benefit into a single bid package, the State would by definition create winners and losers by awarding the bid to a single entity. This would require forced local partnerships between unequal partners (one partner already has the money and the responsibility) and not allow for the time needed to develop effective, collaborative, local relationships.

The WCHO brings the various streams of funding described earlier together to develop integrated delivery policies and strategies. While bringing the public dollars back together at the local county level has provided the necessary resources, it is the creating of local partnerships that has created innovation and the community safety net. The following diagram illustrates graphically how the dollars flow.



Project Funding Specifics

In order to create a sustainable project these systems of care have been built with existing resources. By design grants were not sought for this project. The CMH system has historically relied on grants for creative programming and

systems change. The problem with that approach is that the creativity lasts only as long as the grant funding. The WCHO truly believes that a transformation in how we use the funds available to us is the only sustainable way to effectively move the system forward.

Funding CMH Staff at Primary Care Clinics: At an initial meeting between the CMH Board and the primary care practice information on consumer overlap is discussed. For that first meeting, each system has generated a list of the number of shared consumers that they believe exist between the systems. When the number of shared consumers is greater than 40 (the average case load size at CMH) an existing CMH professional and five hours of psychiatric time can be allocated to that clinic for the provision of on-site mental health services.

The mental health staff remains employees of CMH, is covered by the malpractice insurance of CMH and receives their supervision from a CMH supervisor. The primary care practice assigns a supervisor/liaison for the CMH worker to have for on-site consultation when needed. The primary care practice provides office space and all support functions for the mental health professionals and they are incorporated into the primary care delivery model of the clinic. A formal contract/business associate agreement is signed to cover all legal aspects of this arrangement.

The CMH staff sees anyone referred by the primary care providers, regardless of payment source. By design the CMH Board provides initially two years of funding for these projects from general funds (state and local). During those two years the clinics gather information on who uses the service and what sources of funding/reimbursement might be available for reimbursement. In Year 2 all possible sources of reimburse are explored and contracts and billing mechanisms are established. Given that the WCHO had the four main sources of indigent funding for mental health services (ABW, Medicaid, Mi-Child, and General funds) at its disposal, revenue offsets against the appropriate capitation could be assigned at the back end of services rather than the front end. Billing for the mental health services is completed electronically by the WCHO when consumers served are compared to capitations sources received. The Year 1 funding distribution of consumers across funding sources is identified in Table 3.

Table 3: Funding Sources/Claw backs in Year 1

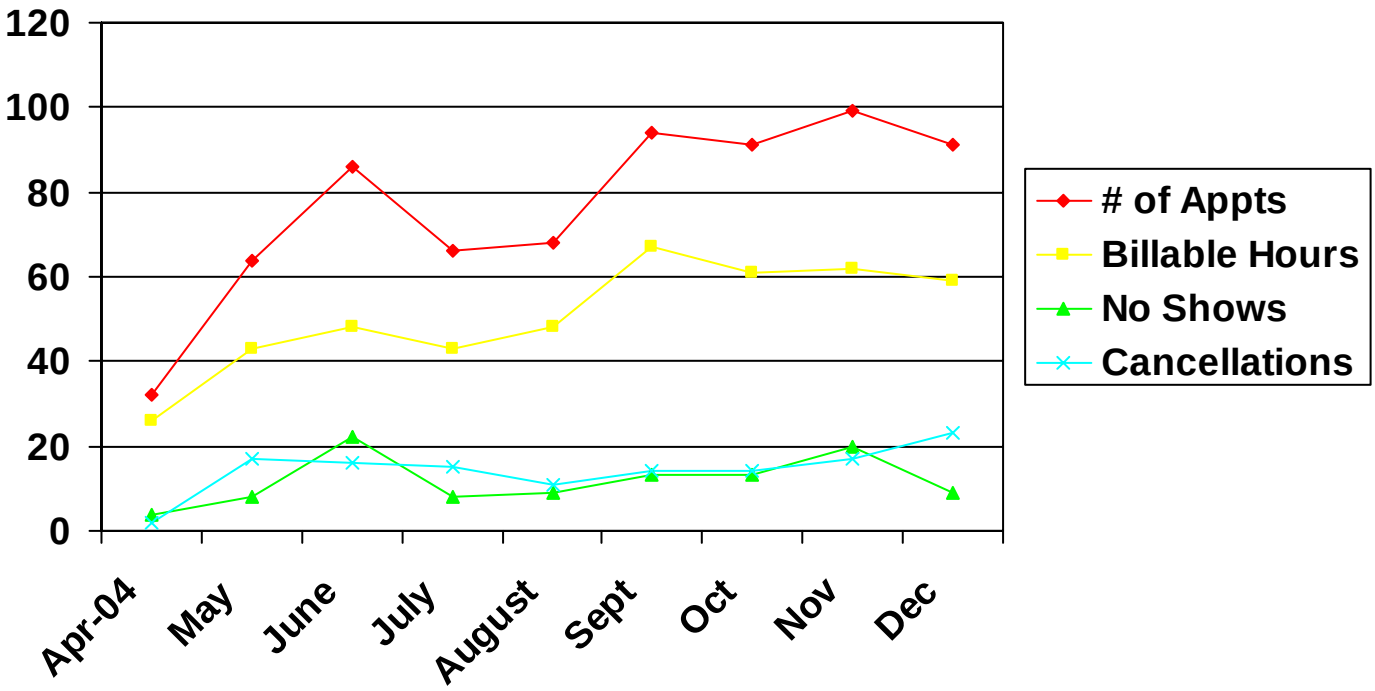
Fund Source	# of Consumers	Capitation Rate Received	Possible Payment Available
ABW	MD: 18 MSW: 7 Duplicates: 5	$328.09 per year x 20 = $6,562	

	Total: 20		
Capitated Medicaid	MD: 24 MSW:23 Duplicates: 5 Total: 42	$515.04 per year x 42 = $22,662	
No insurance/ General Fund MH	MD: 27 MSW: 29 Duplicates: 7 Total: 49	$ 515.04 per year x 49 = $25,237	
Private Insurance	MD Eval: 3 MD Visit: 3 MSW: 13 43 Individual Sessions		$387 $132 $1,339 $2,451
WHP Plan B	MD: 47 MSW: 12 Total: 57		$1,368
Total		$54,461	$5,677
Total Cost for Services	$71,929		

This table demonstrates that the WCHO will recover $60,138 of the $71,929 costs of the program. With an 84% recoverability rate this program is quite sustainable within our community. The offset for the WCHO in this project is that the primary clinic has agreed to begin providing one stop shopping for CMH consumers at the primary care site. In Year 2 of this program, 200 current CMH consumers will be transferred from the public mental health program to the primary site for ongoing, integrated health services. The primary care physician will begin to prescribe the medications the individual would have received at CMH for maintenance of their mental illness. In the event of a problem or concern the consulting psychiatrist will be available to provide assistance and the mental health professional on-site can provide case management or short term therapy as needed.

The receipt of these services at the primary site reduces stigma, increases the likelihood of individuals accessing behavioral health care and improves patient outcomes. When patients from primary care are referred for specialty mental health services, national statistics show that the average no show rates for first appointments ranges from 45-75%. Figure 1 shows that at the first integrated clinic, no show rates for appointments with the mental health professionals have ranged from 5-15%. Increased attendance at appointments improves the consumer health outcomes and saves money for the mental health center in increased productivity.

Figure 1: No-Show Rates at Integrated Health Clinic



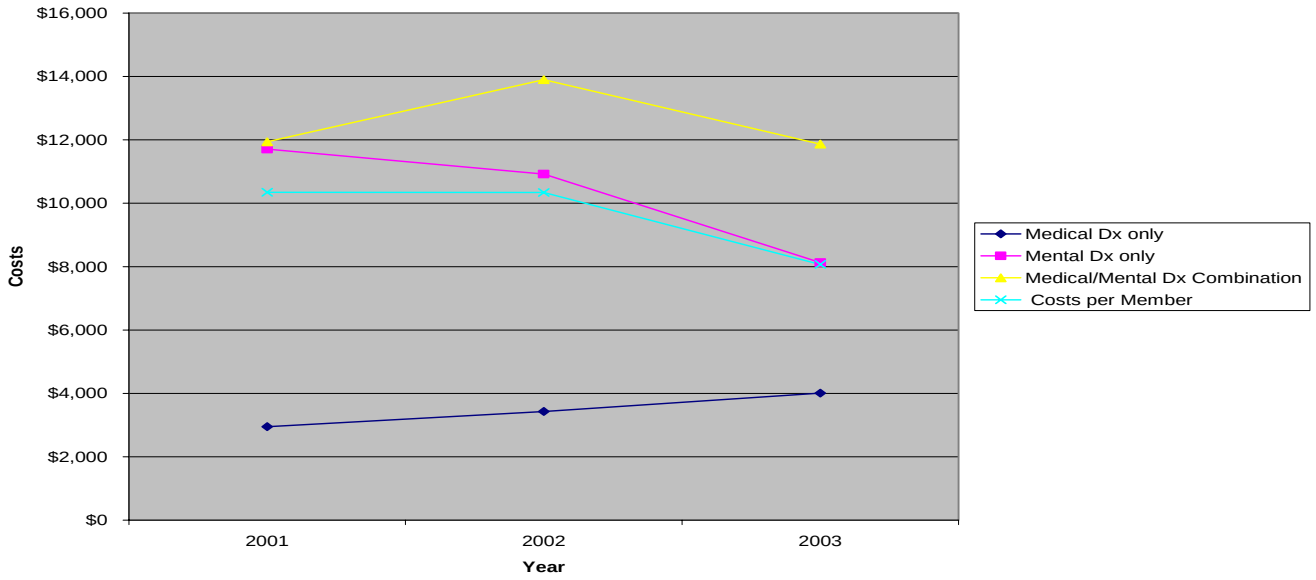
Funding for Nurse Practitioners at CMH Sites: The provision of health services by nurse practitioners (NP) at CMH sites is a cooperative program with the University of Michigan School of Nursing, Community Outreach Program. The University's Nurse Practitioner training program requires that each faculty member have a faculty practice clinic. The WCHO reimburses the School of Nursing a modest rate per hour for these faculty practice clinic staff and pays for the collaborating physician's time for supervising the nurse practitioners. Each half-day clinic costs the WCHO about $7,500 a year. The funding for this service comes from local CMH dollars provided by Washtenaw County. The contract for this service leaves the clinical privileging, supervision and liability costs for the NP with the University, although the CMH's liability insurance does cover nurse practitioners as well.

In the first year of operation, the WCHO received funding from the Blue Cross and Blue Shield of Michigan Foundation to assist with providing this service. BCBSMF provided 50% of the funding of the Year 1 funding. Based on the success of the NP helping consumers get access to housing faster by providing needed physical exams, the uncovering a serious health conditions that required treatment and their success in getting consumers to quit smoking, and the cost effectiveness of these clinics, the WCHO will be expanding NP clinics in the coming year.

Current Funding Initiatives Underway: With the year's worth of data accumulated on payment sources, the WCHO is pursuing several additional sources of revenue. We are engaged in discussion with the local health plans regarding their interest in reimbursing the WCHO for mental health services provided to non-SPMI consumers at primary care clinics. The WCHO is also pursuing Medicaid Health Plan reimbursement for health care visits for Medicaid consumers with the nurse practitioner at CMH clinics.

In these discussions we are using the information included in Figure 2 to justify the Health Plan expenditures for these services. Figure 2 demonstrates that the provision of integrated health care decreases medical and mental health costs. The only costs that have increased in the target population over the two year period are medical care services provided without associated behavioral health services.

Figure 2: Overall Health Savings for Integrated Care in One Health System



In addition to reimbursement from the appropriate capitated plans the WCHO is pursuing the use of the Medicare approved behavioral health codes in a primary care setting. These codes would allow the primary care site to bill for the services provided. The exact mechanisms for this process are currently in negotiation.

Finally, the WCHO is in negotiation with the local primary care health plans to have the "20 visit" portion of the carve-in mental health benefit managed by the

CMH system. This would allow the WCHO even more flexibility in funding mental health care in primary care settings.

Conclusion

At this point you might be saying, “this is all well and good but we don’t have the money or the time to do this”. If, as a system, Community Mental Health is going to take the New Freedom Commission Report seriously, we must be thinking of transforming our systems using existing resources. This integration works and saves money. Figure 2 shows you the actual impact that integrated healthcare has had on one health system in Washtenaw County. By saving money in the system, we save the system for our consumers.

The public mental health system has a tremendous amount to offer primary and specialty care in the “how to” of managing persons with mental health and substance abuse problems. When the systems work together consumers outcomes improve, stigma is reduced and transformation occurs. Transformation requires new ways of doing business. In this model, the CMH system can still provide community based psychosocial interventions. It simply happens out of a primary care setting rather than a traditional specialty care setting. It can happen in your community, in your career and in your lifetime.