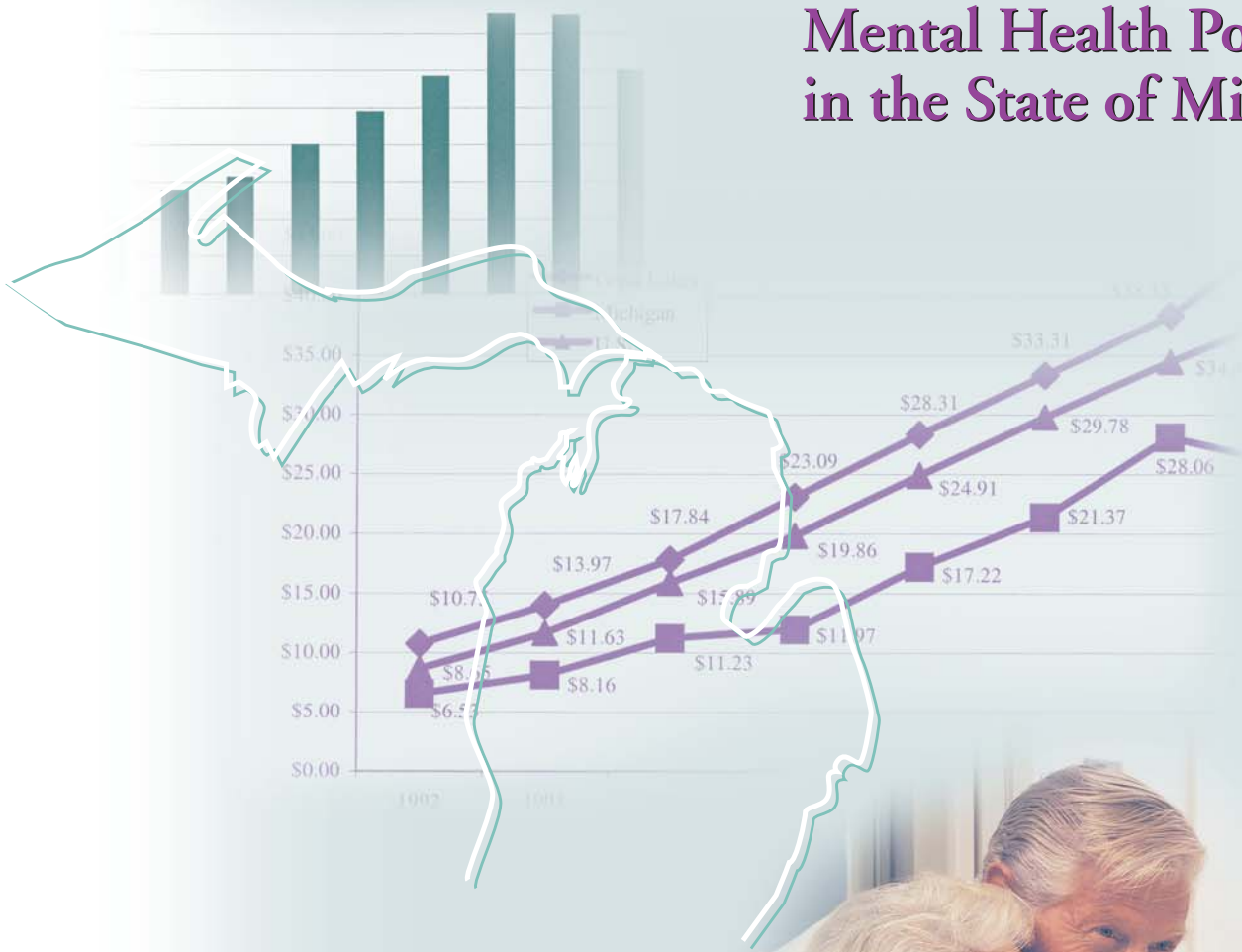


Informing the Debate

Health Policy Options for Michigan Policymakers

Mental Health Policy in the State of Michigan



Author:
Jed Magen, D.O.

Co-Authors:
Carol Barrett, Ph.D.
Maureen A. Mickus, Ph.D.



About this Series

This paper is part of a series entitled **Informing the Debate: Health Policy Options for Michigan Policymakers**. The series is a collaboration between Michigan State University's Institute for Public Policy and Social Research and Institute for Health Care Studies. The papers are designed to inform state and local elected officials and candidates on Michigan's critical health policy issues. They were created to present balanced and nonpartisan background information and possible solutions for this important policy subject area. *Additional copies of the reports are available online at <http://www.ippsr.msu.edu/PPIE> and <http://www.ihcs.msu.edu/policy.htm>.*

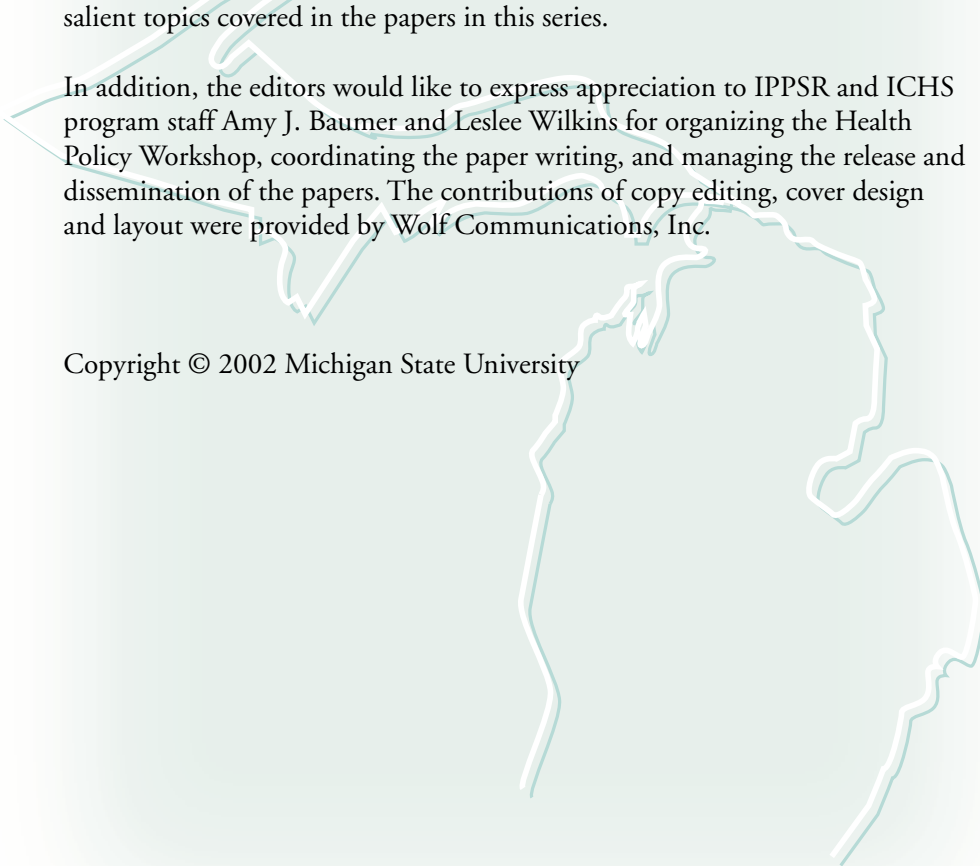
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Author:

Jed Magen, D.O.
Department of Psychiatry

Co-Authors:

Carol Barrett, Ph.D.
Independent Consultant

Maureen A. Mickus, Ph.D.
Department of Psychiatry

Series Editors:

David R. Nerenz, Ph.D.
Institute for Health Care Studies

Carol S. Weissert, Ph.D.
Institute for Public Policy and Social Research

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EXECUTIVE SUMMARY

Large-scale studies demonstrate that up to seven percent of adults and nine to 14 percent of children have serious mental illnesses. Only 20 percent of children with disorder receive treatment. Seven to 13 percent of an average state's Medicaid budget is consumed by substance use and mental disorders. Over 10 years, gross state appropriations for mental health rose by \$850 million dollars.

Michigan has a county specialized mental health system in which Medicaid patients must seek treatment in their county or regional Community Mental Health Center (CMHC). CMHC's are capitated for patients and must provide essentially all care out of this budget. Most states have moved to and the rest are moving toward some variety of managed care plan in order to control costs and perhaps to improve access.

Major issues facing Medicaid mental health in Michigan are the following:

- a) *Workforce issues.* Psychiatrists are in short supply. Michigan has fewer than the national average of psychiatrists and they are extremely unevenly distributed. There are five psychiatry residency-training programs in the state, two of which are threatened with closure by a loss of state funding. How can the state protect its psychiatrist pipeline and help community mental health centers to utilize this limited workforce efficiently?
- b) *The pharmacy formulary system.* Formulary depends on discounts and generics, but generics are not always of equal quality. Will this new initiative decrease pharmaceutical costs and are there alternatives?
- c) *Medicaid mental health parity.* Adverse selection is a problem for all managed care entities with a Medicaid population. How expensive would parity be? What disorders should be covered?
- d) *Access to care.* Access is often limited to those with more severe disorders. Inpatient psychiatry units are closing and families may have to travel long distances to hospitalize family members. Mental health and physical health services are disconnected. Are there existing barriers that are made better or worse by Medicaid managed care? Are there alternatives to the present organization of care?

Most states have moved to and the rest are moving toward some variety of managed care plan in order to control costs and perhaps to improve access.

Policy recommendations for addressing Michigan's mental health policy include:

1. Exploit technology to provide services using existing physicians and physician extenders.
2. Develop mechanisms to allow reimbursement of telemedicine and Internet consultations.
3. Support training within the state.
4. Utilize the present workforce and add to that workforce rather than grant psychologists prescribing privileges.
5. Consider various other outcome measures in addition to drug costs. Better measures of effect may be hospital days, number of clinic visits, or overall medication costs per patient.
6. Consider bottom up as well as top down strategies by encouraging demonstration projects within various CMHC's to test methods of cost effective medication prescribing.
7. Consider parity legislation to help cover the costs of severe mental disorders for adults and for children.
8. Encourage innovation: rather than a "one size fits all" approach, allow CMHC's to innovate.
9. Ensure better coordination and prevent duplication of services.
10. Coordinate services between agencies.
11. Encourage the development and use of more partial hospitalization units/day treatment units.
12. Provide greater availability of group homes.

OVERVIEW OF MENTAL HEALTH POLICY IN MICHIGAN

Mental health policy and treatment issues at a state level are contentious, often chaotic and characterized by policy shifts that often appear to be driven by financial issues and less often by quality research. Due to their disabilities, the populations served often have difficulty accessing services on their own. Many are difficult individuals with whom to work as they may be delusional or have various communication deficits. Nevertheless, psychiatric and mental health disorders are terribly significant in the U.S. population in terms of suffering, use of care-giving resources and financially for states and the country. In *Mental Health: A Report of The Surgeon General*,¹ David Satcher notes that in the Global Burden of Disease Study, mental health problems are responsible for the second largest cause of disease burden in the world, classified as DALY's or Disability Adjusted Life Years.² In established market economies, major depressive disorder is the second leading cause of disease burden, superceded only by cardiovascular disease.

SCOPE OF THE PROBLEM

The scope of the problem is demonstrated by the two large epidemiological studies of mental disorder done in the United States. The Epidemiological Catchment Area Study³ and the National Co-morbidity Survey,⁴ demonstrated that at least 5.4 percent of adults have "serious" mental illness. Up to 28 percent meet diagnostic criteria for a disorder, even if they do not complain of impairment. Individuals with psychiatric and substance use disorders seem to consume about seven to 13 percent of an average state's Medicaid budget.⁵

The data on children and adolescents reveal that about nine to 13 percent of United States children ages nine to 17 meet criteria for "serious emotional disturbance" and five to nine percent, "extreme functional impairment." Nationally only about 20 percent receive some kind of mental health services.⁶ No similar figures are easily available on a state-by-state basis but there is no reason to believe that the situation in Michigan is better than that nationally.

One also needs to recognize that in addition to the public sector discussed here, voluntary support services and the human services sector are also involved in caring for individuals with mental illness. These are often "off-budget" items, but deserve to be included in any real calculation of mental health costs.

This paper discusses current mental health policy issues in the State of Michigan. Based on a review of pertinent literature, discussions with providers and individuals involved in the political process, issues related to Medicaid mental health will be discussed, problems in each area delineated and possible solutions proposed.

Large-scale studies demonstrate that up to seven percent of adults have serious mental illness.

Studies indicate that nine to 13 percent of children have serious mental illness. Nationally, only 20 percent of children with disorders receive treatment.

Seven to thirteen percent of an average state's Medicaid budget is consumed by substance use and mental disorders. In Michigan, over ten years, gross state appropriations for mental health rose by \$850 million dollars.

Michigan has a county specialized mental health system in which Medicaid patients must seek treatment in their county or regional Community Mental Health Center.

MICHIGAN'S MEDICAID MENTAL HEALTH CARE SYSTEM

A number of different Medicaid plan organizations exist across the county:

- a) State-wide carve out plans for mental health services;
- b) County or regional specialized mental health plans; and
- c) Integrated plans providing physical and mental health services fee for service plans.

Michigan's plan is a county/regional specialized mental health plan. Prior to October 1998 when Michigan implemented a managed Medicare reform program, the state Medicaid budget was increasing at an alarming rate. From Fiscal Year (FY) 1987–88 through FY 1997–98, gross state appropriations for mental health in Michigan rose by \$850 million (current dollars), or 78 percent. General Fund/General Purpose appropriations (the best measure of the State of Michigan's contribution) rose by \$287 million, or 38 percent. However, when the effects of inflation and accounting changes are factored in, the increase is more modest in both cases: 15 percent for gross appropriations and just 2.5 percent for General Fund/General Purpose appropriations. This reflects the fact that some significant cost reductions in state hospital inpatient services had all ready been made. By FY 1996–97 the state hospital census had dropped from more than 5,000 to fewer than 2,000, a decline of 62 percent. The number of state employees working in a mental health setting declined from over 11,000 full-time equivalents (FTEs) to slightly over 6,000—or 44 percent. General Fund/General Purpose appropriations to state mental health institutions declined during the period by approximately 60 percent in real dollar terms.⁷

The new program includes carve out services for mental health, substance abuse and developmental disability services through the 49 county-sponsored Community Mental Health Centers (CMHC's). Originally the state envisioned contracting out services to the lowest qualified bidder, but opposition from consumer groups and CMHC's caused this proposal to be dropped. The state hoped to achieve several objectives:

- a) A unification of mental health services on a local level;
- b) Unification of several different funding streams; and,
- c) **Decreased spending contributing to overall Medicaid savings.**

Under this program, CMHC's are paid a capitated rate for services. Each CMHC is mandated to provide certain minimum services and may develop a series of new services. CMHC's in fact, "manage care" so that their capitation is supposed to support any hospitalization as well as outpatient, in-home and community services. They generally contract out to independent agencies for substance abuse services. They have to manage care based on their finite capitation. From the consumer side, individuals enrolled in the Medicaid program are mandated to seek services from the CMHC in the county in which they reside.

This program has had a series of important effects. First, since the CMHC's administrative burden has increased as they are faced with managing care and capitation, smaller CMHC's (under about 20,000 eligible individuals), have coalesced in multiple county CMHC's in order to provide a full range of services and administrative controls. Second, since the CMHC's are now responsible for funding, inpatient hospitalization rates have declined. As hoped, there have been overall fiscal savings to the state as well. In state fiscal year 2000, Michigan spent

\$1.8 billion on specialty services, serving over 244,000 people. This included over 180,000 people with mental illness and over 31,000 people with developmental disabilities. An independent evaluation concluded the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were \$0.01 per eligible person per month (PEPM), while savings for addiction disorders services were \$0.12 PEPM, and savings for developmental disabilities services were \$10.16 PEPM.⁸

EXPERIENCE IN OTHER STATES

Most states have moved to and the rest are moving toward some variety of managed care plan in order to control costs and perhaps to improve access. This was always done in an attempt to decrease costs, or at least contain cost increases. A major difficulty is measuring outcomes and determining whether measured changes are actually due to the institution of a managed care plan. Conclusions regarding state sponsored managed care plans should be taken as preliminary.

POLICY OPTIONS

WORKFORCE ISSUES

Psychiatry-Demand

Any estimates of workforce needs should be approached with some trepidation for several reasons. First, estimating required numbers of psychiatrists and other mental health professionals depends upon one's prior assumptions. As has been demonstrated in the past, a system in which all patients are in a fully managed care model shows the United States to have a surplus of psychiatrists. Other assumptions about models of care can show that we have an adequate number or shortages. Similarly, visits for mental health complaints versus large-scale surveys of psychiatric disorder yield differing levels of need for psychiatrists. Furthermore, researchers are having difficulty determining how much time psychiatrists actually put into patient care and how many are clinically active.

The best available data put the number of psychiatrists in Michigan at 1,340, although this number is not entirely accurate. It is derived from information supplied at time of license renewal. As noted previously, these kind of data do not indicate how many of these psychiatrists are active or retired. They do not indicate part-time versus full-time practice, or in what type of setting these individuals practice.⁹ Noting these limitations, for Michigan, this works out to approximately 13.4 psychiatrists per 100,000 population. The national average is about 16 per 100,000. Michigan has somewhat fewer psychiatrists than the national average. In addition, distribution is a problem, with significant concentrations of psychiatrists in Detroit, Ann Arbor, Lansing, Kalamazoo, Grand Rapids, Petoskey and Traverse City. There are smaller numbers in Flint, Saginaw, Muskegon and Marquette. Child and adolescent psychiatrists are many fewer in number and significant numbers are to be found in Detroit and Ann Arbor. Flint, Saginaw, Lansing, Grand Rapids, Mt. Pleasant, Kalamazoo, Petoskey, Traverse City and Marquette have numbers ranging from 14 to one or two. There are apparently no

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child and adolescent psychiatrists north of a line from Saginaw to Mt. Pleasant to Grand Rapids to Muskegon until one reaches Petoskey and Traverse City.

Examination of demand for psychiatric services in Michigan reveals that most general psychiatrists have waiting lists. All child and adolescent psychiatrists have waiting lists. Lansing probably has more child and adolescent psychiatrists than any cities other than Detroit and Ann Arbor. Waiting lists in Lansing are on average about six weeks. An informal survey of Community Mental Health Centers across that state indicates that many urban and rural centers report that they need more psychiatric services.

The evidence indicates that Michigan has fewer psychiatrists than it needs both in the public sector and in the private sector. Child and adolescent psychiatrists are in very short supply. There are also negligible numbers of geriatric psychiatrists, addictions medicine psychiatrists and forensic psychiatrists. There is also a maldistribution problem with psychiatrists concentrated in cities and few in rural areas. Michigan mirrors the national situation in this regard and is in competition with other states for psychiatrists.

Examination of demand for psychiatric services in Michigan reveals that most general psychiatrists have waiting lists. All child and adolescent psychiatrists have waiting lists.

Psychiatry-Supply

Michigan has five psychiatry residencies producing psychiatrists. These include two programs in Detroit (Henry Ford Hospital and Wayne State University), one in Ann Arbor (University of Michigan), one in Lansing (Michigan State University) and one in Kalamazoo (Kalamazoo Center for Medical Studies, a Michigan State University Community Campus). These five programs admit approximately 30 residents each year to four-year programs. There are two child and adolescent psychiatry residency programs, one in Ann Arbor at the University of Michigan and one in Detroit at Wayne State University. These two programs admit approximately nine residents per year, usually after three years of general psychiatry training. Characteristically, some residents go on for more advanced fellowship training, so that there are about 20-25 psychiatrists graduating each year available for practice. Some of these individuals will leave the state so that we probably have no more than 20 psychiatrists each year who may start psychiatric practices in the State of Michigan.

In October 2002, Wayne State University and Michigan State University were notified that funding for their psychiatry residencies had been terminated by executive order of the Governor. These funds amounted to approximately \$3.2 million per year for Wayne State University and \$535,000 for Michigan State University. Absent these funds, Wayne State reported it would have to cut its General Psychiatry Residency program by 50 percent and consider closing its Child and Adolescent Psychiatry Residency program. Michigan State University would close its psychiatry residency. The number of positions lost represent about one fourth of all general psychiatry positions in the state.

The psychiatry residency at Wayne State University is funded partially by Graduate Medical Education (GME) revenues from hospitals and partially from state funding sources as noted above. Approximately 50 percent of Wayne State's residents are funded through the state. Absent state funding, the residency would be 50 percent smaller. Although hospitals do receive GME funding mostly through Medicare for residency training, there is a cap on the numbers of residents each hospital may fund through federal mechanisms. This cap was put into place in 1996 at which time Wayne State was funding one-half of its psychiatry residents through

It is doubtful that the state is currently producing enough psychiatrists to maintain present service levels.

state funds. With hospitals all ready at their cap limit, it is not possible for them to absorb the extra Wayne State residents.

At Michigan State University, rotations for residents at the local Community Mental Health Center and in the university clinic are funded by state funds. These are precisely the rotations that are important in persuading residents to work in public-sector settings. In addition to the cap issue noted above, Michigan State has the added problem of these rotations not being in a hospital. This also makes hospitals more reluctant to fund them.

In each program, large numbers of residents stay in Michigan and provide services in public-sector settings. Eighty percent of Michigan State University graduates practice in Michigan and 55 percent work in public-sector psychiatry. The numbers from Wayne State University are similar, but slightly lower.

With the average age of psychiatrists in Michigan estimated to be approximately fifty-three, it is doubtful that the state is currently producing enough psychiatrists to maintain present service levels. Nationally, there are approximately 800-850 graduates of psychiatry residency programs each year. These individuals have a choice of many positions. Absent some ties to Michigan, there are many other attractive locations for practice. Many settings in Michigan are at a competitive disadvantage when recruiting psychiatrists from out of state. As well, recruiting costs are larger for out of state individuals than for residents in programs in the state.

The inescapable conclusion is that Michigan will, like the rest of the nation, continue to have a shortage of general and child and adolescent psychiatrists. This shortage exists in all most all settings in the state. Closing psychiatry residencies will exacerbate this shortage, especially in more rural areas where graduates of these two programs settle in greater proportion than is true of other programs in the state. Elimination of these positions will result in fewer psychiatrists trained in Michigan and fewer available to provide services in the public and private sectors. The already serious shortage of psychiatrists will be exacerbated. Not all medical students in state medical schools will be able to enter psychiatry residencies in the state. Michigan will be using public funds to educate medical students who will go to other states for residencies. Since one of the primary determinants of where a physician will settle is the location of his/her residency program, assuredly, we will have fewer psychiatrists practicing in Michigan.

Psychologists Prescribing Privileges

In recent years, the American Psychological Association has been lobbying in a number of states to gain prescription privileges for psychotropic drugs for psychologists. This effort is usually based on unavailability of psychiatrists in rural settings and resulting lack of care for individuals with psychiatric disorders. Prescribing courses of various lengths are offered as the primary vehicle for educating psychologists to prescribe these medications. While this superficially seems to be an attractive option to increase the numbers of mental health professionals providing medications, there are a number of important issues needing further investigation. Clearly, psychology and psychiatry training are very different. Psychiatrists spend four years in medical school, then spend four years in a psychiatry residency program learning to deal with both psychological issues using psychotherapy techniques and to approach psychiatric disorders with the use of medications. Psychologists enter PhD programs taking five to seven years. Education and experience in the use of psychotropic medications is not present and

With the average age of psychiatrists in Michigan estimated to be approximately 53, it is doubtful that the state is currently producing enough psychiatrists to maintain present service levels.

It is unrealistic to expect anyone to become a competent psychopharmacologist without prior medical training, pharmacology training and dedicating significant amounts of time and significant immersion in patient care...

Developing a program for prescription privileges for psychologists constitutes a large-scale experiment for which there is very little data.

there is no education in other medical issues, pharmacology, physiology, physical diagnosis or the care of individuals with other medical disorders. Psychiatrists are trained in the medical tradition of differential diagnosis during which a physician develops a list of disorders consistent with the patient's symptoms. This is not a skill emphasized in psychology training.

Experience with psychiatry residents demonstrates that one can learn beginning prescribing skills in five or six months of full-time intensive training on an inpatient psychiatry unit. However, developing sophisticated psychopharmacologic skills takes two to three years. It is unrealistic to expect anyone to become a competent psychopharmacologist without prior medical training, pharmacology training and dedicating significant amounts of time and significant immersion in patient care.

Other professionals who have prescribing privileges include nurse clinicians, physician assistants and optometrists. In most cases, these are partial privileges and some supervision is needed. In each case, these individuals come from a medical tradition where there is training in differential diagnosis and other medical disciplines totally unlike psychology training. There are no data on psychologist prescribing other than a small military program that has since been terminated, that might be helpful in determining the usefulness of such a program. Developing a program for prescription privileges for psychologists constitutes a large-scale experiment for which there is very few data sources available. Many other questions would also need to be answered regarding such a program. What classes of drugs would be included? Would anyone providing therapy services with a doctoral degree be included, or only those individuals with PhD's as contrasted to those with Psy.D's and Ed.D degrees. Both accredited and unaccredited programs exist granting these degrees. Would individuals from unaccredited as well as accredited programs be eligible?

Finally, it is not at all clear that allowing psychologists to prescribe psychotropic medications would help the maldistribution problem we now have. Rural and inner city areas are generally less attractive locations in which to practice and psychologists are not any more likely to settle in these locals than are physicians.

MEDICATION COSTS

Formulary

The State of Michigan recently developed and put into place a formulary system for Medicaid recipients. The intent of this formulary is to decrease drug costs by having fewer medications routinely available, and negotiating large discounts from pharmaceutical companies for these medications. Non-formulary medications can be prescribed, but physicians must obtain preauthorization which involves completing forms and/or calling the preauthorization agency. This formulary does include psychotropic medications. Since community mental health centers provide the largest proportion of psychiatric care to Medicaid recipients, they (and their patients) are most affected by choices of formulary medications.

Michigan expects to save money over the long-term by influencing physicians to prescribe less costly medications. In this scenario, patients who are started on new medications will be started on the less expensive formulary approved products. If a patient does not do well on the first medication, the state hopes the physician will switch the patient to another formulary product, of which there seem to be at least two in each class. For patients who respond to the first or second agent used, this is not a problem. However, the state also expects to save money over the short term,

that is, the 2002-2003 fiscal year by influencing physicians to switch existing patients from more expensive medications to less expensive ones.

The formulary system presents several potential problems:

- a) There are many patients who are doing very well on their existing medication. If this is not a formulary product, the state may wish to influence the provider to switch that patient to a formulary product. For a schizophrenic patient who is doing well on drug X (nonformulary), switching to drug Y, (formulary) is not clinically indicated. There are, in fact, no good data to indicate that schizophrenic patients can be safely switched from a medication to which they are responding to another medication. This would constitute a large-scale experiment without being stated as such.
- b) One expects that patients would take a dim view of such a medication change. It is also possible that more patients would need hospitalization and costs might actually increase.
- c) Not all patients respond to all medications. There will always be a subgroup of patients who need trials with a variety of medications or who need to be on combinations of medications.
- d) In the Michigan formulary program, each time a non-formulary medication is to be used the physician will have to request approval. It is not clear how long the approval process will take, but for physicians all ready stretched for time, any extra paperwork is an added burden. If the approval process takes some time, patients may not be able to take advantage of more effective treatments as quickly as is medically indicated. Preauthorization further increases paperwork and time commitments and could also be an added factor driving physicians away from public sector work and from caring for Medicaid patients. This constitutes a further disincentive to work in the public sector for psychiatrists and nurses.

Formularies are in part based on the assumption that generic medications are equivalent to brand name products. In fact, this key assumption is not always true. Although one is getting the same medication, by federal law, generics are allowed to be 125 percent to 70 percent as “bioavailable.” This means that the average patient may be getting 70 percent to 125 percent as much medication as the reference brand product. This variability may or may not be important. Recently there are reports of depressed patients suddenly becoming symptomatic again when switched to generic Prozac.

Furthermore, the first year or two of formulary prescription practice may not save Michigan as much money as expected. Physicians may make requests for the present non-formulary product for current patients. It is also possible that current patients switched to new medications may deteriorate and need hospitalization or increased intensity of outpatient services, and/or more medication. Although total drug costs may diminish based on prescription of more formulary products and fewer non-formulary medications, Michigan will have to look carefully at other costs to determine if these might increase and for unintended consequences.

Formularies are in part based on the assumption that generic medications are equivalent to brand name products. In fact, this key assumption is not always true.

In reference-based pricing, a common level for reimbursement is established for a group of comparable or interchangeable medications.

Reference-Based Pricing

Another strategy for containing medication costs is that of reference-based pricing, which is used extensively in Europe and to some extent in Canada. Reference-based pricing is one step beyond generic substitution. In generic substitution, a lower-cost generic version of brand name medication can be substituted for the brand product.

In reference-based pricing, a common level for reimbursement is established for a group of comparable or interchangeable medications. Thus, a patient may get a medication that is chemically different, but has the same general effect. Generally, reimbursement is set at the price of the lowest cost drug in its class. A recent report regarding the system used in British Columbia demonstrates that it initially decreases costs, but over the longer term, drug costs seem to accelerate again. While this system does hold down costs for individual medications, it does not control increases in volume. It also has difficulty with new medications that are the sole medication in class.

MEDICAID MENTAL HEALTH PARITY

By the early 1990s, a typical health plan under managed care covered only 30 inpatient days a year for mental illness, compared to 120 to 365 days for other illnesses, and covered no more than 20 outpatient visits, compared to unlimited visits for physical problems. The patient with a mental or addiction problem had to pay a far greater share of the costs of each clinic visit or hospital bill than did one with a medical or surgical problem, and the typical plan had a relatively low \$50,000 lifetime ceiling on mental health or substance abuse benefits, compared to a \$1 million ceiling or no ceiling on other illnesses. Many mental disorders were excluded from any coverage at all.¹⁰

There is no question that treatments for psychiatric disorders including addictive disorders have become more effective. As well, there are now better methods for managing costs of these disorders. These two phenomena as well as more effective mental health issues groups, bring mental health parity to legislatures as current issues.

Parity has had, and will continue to have a difficult time for a couple of reasons. Mental health care is often seen as a “bottomless pit” and benefit parity is seen as potentially breaking the state Medicaid budget. In addition, there is a prevailing attitude in many sectors of society that mental illness is a personal problem, the result of some kind of lack of control. If those with mental illnesses wanted to recover, they just have to “pull themselves up by the bootstraps” or some similar sentiment. Clearly, the basis of much mental illness is biological with strong psychosocial inputs, however these kinds of attitudes are a not inconsequential barrier to such legislation.

Nevertheless, as of January 2001, 38 states had passed some version of parity legislation. Several examples are instructive.

- a) California’s law mandates equal coverage for severe mental illnesses which including schizophrenia, bipolar disorder, major depressive disorders, schizoaffective disorder, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa, and bulimia nervosa. Children with mental disorders other than a substance abuse or developmental disorders are covered for these illnesses and there is no exemption for small businesses.

- b) New Hampshire implemented partial mental health parity in 1995. This was really an incremental change, since not all disorders were covered. The New Hampshire legislative act requires insurers and plans to "provide benefits for treatment and diagnosis of certain biologically based mental illnesses [8 specified] under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness"¹¹ The 1975 minimum coverage floor for insured benefits of \$3,000 for annual care and \$25,000 for lifetime benefits continues as well as those certified providers of mental health services.
- c) In the Midwest, Indiana law passed legislation in 1999 to cover "services for mental illness,"¹¹ as defined by a contract, policy or plan for health services. It does not require coverage of substance abuse treatment. It exempts small businesses.
- d) Minnesota law requires that the "cost of inpatient and outpatient mental health and chemical-dependency services to not be greater or more restrictive than those for outpatient and inpatient medical services."¹¹

The Lewin group did a survey for the National Alliance for the Mentally Ill in order to understand the effects of the New Hampshire legislation. Most insurers in the state were surveyed. The effect of the legislation was reported to be as follows:

"Before 1995 there were benefit limitations on mental illness treatment regardless of diagnosis; generally patients were allowed 20 outpatient visits with a co-payment and 35 days of inpatient care per year. Since the legislation was implemented, patients diagnosed with one of the biologically based mental illnesses are allowed essentially unlimited care based on medical necessity. Other mental illnesses (outside of the eight provided in the law) are dealt with in the same manner that they were prior to the legislation."¹² As it turns out, respondents did not attribute any change in premium to the mental health parity legislation.

Instead, in order to cope with the new legislation, insurers expanded case management protocols for serious illness. After the first five visits to a mental health professional authorized without review for medical necessity, some organizations assign patients to a case manager who conducts periodic reviews for medically necessary treatment. Long-term treatment plans, regardless of whether they are for physical or mental illness, may go to a case manager for concurrent utilization management and case review. Case management may even occur before the five visits are complete if the patient is diagnosed with a biologically based mental illness (one of the eight specified by law). In some situations, the insurer has required that the patient obtain a second medical opinion.¹²

Another national survey of states with parity legislation done by Sturm concluded, "Although there are no statistical significant effects of state parity, parity mandates are associated with a slightly higher number of mentally ill reporting improved insurance generosity and access to care. However, the number of mentally ill losing all insurance coverage has also increased in parity states."¹³

Although there are no statistically significant effects of state parity, parity mandates are associated with a slightly higher number of mentally ill reporting improved insurance generosity and access to care.

However, the number of mentally ill losing all insurance coverage has also increased in parity states.

In all states, coverage is provided for only a limited number of severe psychiatric disorders rather than for a full range of disorders. Full parity does not exist.

The most fundamental issue is that the effects of parity on coverage are at this point in time very difficult to understand for the following reasons:

- a) States were moving individuals into managed care settings at the same time as they were passing parity legislation.
- b) In the private sector, company workforces were covered by a number of different plans with different benefit packages thus making comparisons very difficult.
- c) In all states coverage is provided for only a limited number of severe psychiatric disorders rather than for a full range of disorders. Full parity does not exist.

MEDICAID FINANCING

General Issues

The following section discusses Medicaid financing in general. Although not directly related to mental health issues, a general understanding of financing is important to understand Medicaid mental health carve outs and other mechanisms for financing mental health care.

Most states have moved Medicaid populations into managed Medicaid plans through the ninety's and into the twenty-first century. This was always done in an attempt to decrease costs, or at least contain cost increases. At first states often contracted with commercial plans. Over the last several years large numbers of these plans have left the Medicaid market due to poor reimbursement rates, adverse selection and difficulties with the administrative demands made by Medicaid bureaucracies.¹⁴ In response, states have made some adjustments in the process, especially for rate setting. Rates are set in one of several ways:

- *Administered price setting:* Rates are set by the state for all MCO's willing to participate and these are often derived from previous fee-for-service data. These fees are then discounted by some amount.
- *Rate negotiation:* A rate may be negotiated with each plan, or rates may be negotiated with all plans at once.

Competitive Bidding

- Arizona currently competitively bids and negotiates its rates. Five-year contracts are negotiated, but there are adjustments for inflation and other changes. The state developed a set of rate ranges for bidding. Rates were not disclosed to plans. Rate ranges were developed using past years Medicaid expenditure data. They were also adjusted to take into account various other programmatic issues including the cost of reinsurance and third-party recoveries, administrative costs, expected profits, and other contingencies.
- Hawaii competitively bids contracts every three years. In the recent past, rates have remained the same or have been lowered. Plans that passed technical review discussed with the state's actuary assumptions used to prepare bids. They were then made final adjustments to their submitted bids. Hawaii is changing its process so that it will begin disclosing rate ranges and will require plans to submit bids within the range.

- New York has a somewhat more complex system. It competitively bid rates across a series of counties in 1996. Ranges were set at plus-or-minus five percent of a discounted fee-for-service midpoint for a series of age and gender groups for each of nine groupings of counties. Plans that bid below the range for a group were brought up to the lower payment limit, and plans that bid within the range were contracted at bids. For plans that bid above the range, the state set their rates at the lower payment limits as well. Nearly two-thirds of the plans had rates set at the lower payment limit.

Soon after the 1996 process, plans claimed that rates were too low to cover eligible populations. In response, the state commissioned an independent study by Arthur Andersen, Inc., which concluded that rates were not adequate and recommended a three to five percent increase in capitation payments. Since the 1996 study, the legislature has continually raised rates. Together, these rate adjustments could have potentially increased plans' rates from 13 to 25 percent since 1996. New York intends to negotiate rates with individual plans in the future.

- Finally, the State of Washington competitively bids contracts every three years, with interim adjustments for changes in service coverage, budgeted utilization trends, and inflation. During the recent process, many of plans bid above the state's undisclosed upper payment limit. As a result, the state had to receive legislative approval for an increase in rates to ensure adequate participation.

Most states exclude Disproportionate Share payments from capitated Medicare payments, and most states exclude Graduate Medical Education Payments.

In large measure, mental health care (behavioral health) is carved out of these pools. In California, responsibility for mental health services for Medicaid beneficiaries is contracted to separate county organizations. The Medicaid agency transfers a portion of general revenues to the State Department of Mental Health to cover costs for mental health care previously provided through the Medicaid agency. The State Department of Mental Health then allocates these funds to individual counties, following an allocation formula based on historical utilization of Medicaid mental health services, the number of Medicaid beneficiaries, and other relevant factors. Counties then pool these funds with a portion of proceeds from motor vehicle and sales taxes that are earmarked for mental health services and federal matching payments to provide services to Medicaid beneficiaries. The county organization is free to contract with independent providers on a fee-for-service or capitated basis. Substance abuse treatment is also carved out, to the Division of Alcohol and Substance Abuse

Medicaid Disproportionate Share Funds

Michigan has been aggressive in its efforts to earn federal matching funds through the Medicaid program. The primary vehicle for these efforts has been use of the disproportionate share hospital (DSH) program and provider payment adjustments, with the state share financed with intergovernmental transfers. An indication of the scope of Michigan's effort is that, in 1996, more than one-third of the state appropriation for Medicaid consisted of intergovernmental transfers rather than general-fund monies. The state and other states are able to do this through extensive use of Disproportionate Share Funds (DSH) and related payment systems. In brief,

Funding also comes from Disproportionate Share Funds.

Federal funds paid to states are determined by a formula that considers a state's average per capita income relative to the national average. In addition to Medicaid payments to providers and hospitals, Disproportionate Share Funds are paid to hospitals that have high proportions of Medicaid and other low-income patients.

Access to services is often limited to those with more severe disorders.

...due to declining reimbursement rates it appears that increasing numbers of psychiatrists are opting out of managed care programs.

Medicaid is a shared cost between the Federal Government and states. Federal funds paid to states are determined by a formula that considers a state's average per capita income relative to the national average. In addition to Medicaid payments to providers and hospitals, Disproportionate Share Funds are paid to hospitals that have high proportions of Medicaid and other low-income patients. Essentially, the state puts up matching funds, which the Federal Government then supplements at a particular percentage match rate.¹⁶ States have thus been able to use their own funds, or even put up hospital funds for Federal matching dollars and fund various expenditures, including in the mental health area, state psychiatric hospitals and the funds for the psychiatry residencies at Wayne State University and Michigan State University. Using hospital funds has the added advantage of not dipping into state funds at all.

A very common problem for any Medicaid managed mental health setting is adverse selection. Individuals in lower income categories have proportionately more, more severe and more pervasive mental health problems. They tend to cluster preferentially in managed care settings where care is available. These issues make their care more expensive, and often unprofitable for managed care entities. Private sector managed care organizations can and do choose to pull out of this market. On the other hand, CMHC's have to serve this population and when faced with adverse selection phenomena have to respond differently. They tend to begin cutting services in order to balance capitation with expenses. Thus, disadvantaged populations may be receiving a different quality of care.

Michigan has increased its reliance on DSH funding through the 1990's. It is not clear that the Federal Government will continue to permit states to use DSH funds as liberally as in the past. If DSH funding match requirements become more restrictive, the state will have to fund these activities or further cut Medicaid budgets.

ACCESS TO MENTAL HEALTH SERVICES

Michigan has attempted to improve access by designating county-based CMHC's as the exclusive provider for mental health services. The state obviously hoped that providing CMHC's with what was thought to be a stable base of funding and a defined population base would encourage them to develop better methods of service provision and access.

However, services can be difficult to access. Rather than a direct referral to a provider, families may have to have an intake appointment first, and then be referred to another provider for services. This situation may apply in both private and public sectors. It disrupts the relationship between referring physician and mental health clinician. It adds an extra step to the process and may increase the time between referral and treatment. Monetary issues which include co-payments that can be higher than for non-mental health visits and limits on numbers of visits also inhibit care. Furthermore, due to declining reimbursement rates it appears that increasing numbers of psychiatrists are opting out of managed care programs. Individuals wishing care must make full payment and then accept reimbursement directly from the MCO. This initial charge is a limiting factor for many families and individuals.

From the private provider perspective, Medicaid reimbursement for services often does not even cover overhead costs. In effect, the state is asking private practitioners to subsidize services to Medicaid patients. This is neither fair nor

realistic. In practice individuals with Medicaid are seen at Community Mental Health Centers or some university clinics. There are few to no other choices due to the reimbursement issue.

Access is also affected by availability of providers and services. Most hospitals do not have general inpatient psychiatric units. These units are not as profitable as other specialized types of services. In fact, over the last 10 years a number of hospitals have closed psychiatric units. Units have closed in Detroit and Grand Rapids. Mt. Pleasant lost its only inpatient psychiatric service. As a result, adults with psychiatric disorders may have to travel considerable distances for hospitalization. Characteristically, children and adolescents have to travel much farther. For instance, children and adolescents from the Lansing Metropolitan area have to travel one hour to the University of Michigan, or one and one half hours to Pine Rest Christian Hospital for psychiatric hospitalization. This is an added burden to families all ready in turmoil. As noted in the section on workforce, providers are also in short supply.

Another issue involving access is the integration of mental health services with general medical services. This is problematic in carve out situations. Services and responsibilities provided by each sector must be clearly delineated. Furthermore, in settings where all care is provided by one organization, there is often only a small share of resources provided for mental health services.

CLINICAL ISSUES

Lastly, the non-physician reader should gain an understanding of how clinical treatment issues interact with financial imperatives under Medicaid to create severe problems for psychiatrists attempting to provide quality treatment for individuals with psychiatric disorders. First, since hospitalization is expensive and CMHC's must pay for hospital days out of their capitated rate, there is a strong incentive to keep patients out of the hospital and to erect barriers to hospitalization if there is any alternative at all. In response, hospitals have altered criteria for hospitalization so that they can screen out those patients who will not have days authorized by the CMHC. In practice, the only criteria for hospitalization are severe suicidality and or severe homicidality or an inability to adequately care for oneself such that one is at risk of severe injury or death. This means that some less suicidal patients are not admitted, and many chronically psychotic patients are not admitted unless they meet above criteria. Patients who are psychotic and in need of hospitalization may have to deteriorate until they do meet criteria.

In addition, it has been known since antidepressants were first introduced to medical practice some 45 years ago that many patients do not begin to respond with decreases in depression and suicidality for two to eight weeks after starting medication. Yet, average psychiatric hospitalization length of stays are in the range of eight to 12 days in most hospitals. This is clearly due to the cost imperative and has little to do with clinical response to medication, or what is in patient's best interests. Many depressed patients do have insurance, and this situation is not unique to the public sector. Another major cause of hospitalization is worsening of chronic psychosis caused by schizophrenia. Given the pressure to discharge patients in order to save capitated funding, patients are now routinely given added medications in order to try to reduce the psychosis very quickly. This practice has little support in the psychiatric treatment literature, and in fact, it there is every possibility that patients are increasingly treated with multiple medications in ways that are not supported by medical literature. Before blaming the treating

Inpatient psychiatry units are closing and families may have to travel long distances to hospitalize family members.

Another issue involving access is the integration of mental health services with general medical services... there is often only a small share of resources provided for mental health services.

psychiatrists, consider that the pressure to discharge comes from CMHC's and the hospitals, since at some point, CMHC's will simply have to stop paying for hospital days due to their own reimbursement. It is unfortunate and ethically troubling that clinical care and financial imperatives interact in such a way that finances drive decisions about clinical care.

POLICY RECOMMENDATIONS

Policy solutions take advantage of creative mechanisms for dealing with these issues. Specific recommendations are as follows:

1. Exploit technology to provide services using existing physicians and physician extenders.

Maldistribution problems can be partially addressed in several ways. Psychiatrists from Marquette travel extensively to community mental health centers in many locations in the Upper Peninsula (UP). A full-time psychiatrist could not be supported in many of these rural settings. In at least one UP location, family practitioners with an interest and some training in mental health have prescribed medications to patients in community mental health settings. In the northern reaches of the Lower Peninsula, psychiatrists also travel to various Community Mental Health Centers. In some states, psychiatrists at university centers examine patients via telemedicine technology either prescribing directly, or providing consultation to psychiatrists or family practitioners in these settings. This technology is viable in Michigan and could be exploited to bring more psychiatric expertise to rural settings. Reimbursement for this service is generally not yet available, which is a rate-limiting factor in developing this service.

2. Develop mechanisms to allow reimbursement of telemedicine and Internet consultations.

In addition to telepsychiatry, further training in psychopharmacology and the provision of mental health services would make interested family physicians and nurse clinicians more effective providers for rural mental health settings. The ready availability of consultation by televideo or even internet e-mail or instant messenger services would also improve care by developing close and convenient contact between psychiatrists and other clinicians caring for patients with psychiatric disorders. These mechanisms can also be used to make university psychiatrists more available to colleagues in more isolated areas of the state. In order to facilitate these kinds of contacts, Michigan would need to develop mechanisms to allow reimbursement of telemedicine and Internet consultations.

3. Support training.

If Michigan is to have even near adequate numbers of psychiatrists, it must support training within the state. Savings of \$3.7 million a year by not funding psychiatry residencies will result in the loss to the state of approximately 20 new psychiatrist graduates each year. The state would incur additional recruiting costs for out of state psychiatrists and increases in the burden of psychiatric disease due to inadequate treatment. It would also be extremely difficult to attract 20 additional psychiatrists to Michigan. The state should continue to fund psychiatry residency training. As has been done the past several years, the state should utilize for at least a part of

In some states, psychiatrists at university centers examine patients via telemedicine technology either prescribing directly, or providing consultation to psychiatrists or family practitioners in these settings. This technology is viable in Michigan and could be exploited to bring more psychiatric expertise to rural settings.

residency funding Medicaid DSH funds. The DSH fund provides federal matching dollars for state funds. Since psychiatry residency programs see disproportionate shares of low-income patients in comparison to private practitioners, this is a very legitimate use of DSH funds. The state could also assist programs by working with them to provide venues for experiences necessary for accreditation but difficult to obtain, such as psychiatric forensic rotations. These could be supported at the program cost for training residents, approximately \$50,000-\$90,000 per FTE resident with only a few residents per year needing such rotations.

4. Avoid creating a new class of practitioners.

As noted above, there are some mechanisms available to modify the maldistribution of psychiatrists. Other physicians can treat some psychiatric disorders, as can Nurse Practitioners and Physician Assistants. More efficient utilization of our present workforce and adding to that workforce are less speculative than creating a new class of practitioners.

5. Michigan should consider various other outcome measures in addition to drug costs.

In the long run, the state may have to recognize that drug costs are not as controllable as hoped. Neither formulary systems nor other systems seem to be able to control costs over more several years. Recently developed, and more expensive medications often are more effective than older medications and this is clearly true for newer “atypical” antipsychotic medications used for schizophrenia and for selective serotonin reuptake inhibitor antidepressants like Prozac. However, it is not clear that total costs are higher. Studies consistently demonstrate that for both these classes of medications, outcomes are better and overall costs seem to be similar or better than those of older, less expensive medications, since patients have fewer side effects and are more likely to take medications more consistently. It may therefore be misleading to examine only drug costs. Better measures of effect may be hospital days, number of clinic visits, overall medication costs per patient or various other outcome measures.

6. Consider bottom up strategies.

Michigan’s response to escalating drug costs has been a top down solution. From a management point of view, empowering and enabling employees is a powerful strategy for promoting change. In some hospital systems, physician education and feedback regarding both prices and alternative effective medications has been effective in changing physician behavior and promoting more cost effective behavior. The state should consider bottom up as well as top down strategies by encouraging demonstration projects within various CMHC’s to test methods of cost effective medication prescribing.

7. Consider parity legislation.

Although everyone fears huge cost increases, experience in Minnesota, Massachusetts and Maryland indicate small to no cost increases although importantly, none of these states have parity for all mental disorders. The verdict on parity is still out, pending more experience in more stable settings. It appears though, that at least partial parity for some severe disorders does not increase costs

Savings of \$3.7 million a year by not funding psychiatry residencies will result in the loss to the state of approximately 20 new psychiatrist graduates each year. The state would incur additional recruiting costs for out of state psychiatrists and increases in the burden of psychiatric disease due to inadequate treatment.

significantly. Michigan should consider parity legislation to help cover the costs of severe mental disorders for adults and for children.

8. Encourage innovation.

Rather than a “one size fits all” policy, Michigan should allow CMHC’s to innovate, much as the Federal Government has allowed states through Medicaid waivers. Some innovative programs do exist such as Washtenaw County’s arrangement with the University of Michigan. This program is unlikely to be able to be reproduced elsewhere given the unique nature of the University of Michigan’s resources.

9. Ensure better coordination of resources.

Despite the integration of the Departments of Community Health and Mental Health, there are still a plethora of agencies, both public and private, providing mental health care to the Medicaid population. In addition to CMHC’s, county jails, the state prison system, various social services agencies, school systems and the state’s three university-based departments of psychiatry all provide services to individuals with Medicaid. Better coordination of services and preventing duplication would be helpful. The Children’s Health Insurance Programs (CHIP) do not cover mental health services. Expanding this program’s coverage to include mental health would tap into new resources and permit better coordination of mental and physical health resources.

10. Coordinate services between agencies.

Coordination of services between agencies may help CMHC’s by providing services for some patients who would otherwise be seen by CMHC’s. These would likely be individuals with less severe disorders. The various agencies providing mental health services in local areas should have a regular means of coordinating programs and care. Patients might be triaged, and designated to see by particular agencies other than CMHC’s in their area.

11. Encourage the development of more partial hospitalization units/day treatment units.

Given the increasing scarcity of inpatient psychiatry units and the longer distances families and patients need to travel to access units, the state should give consideration to encouraging the development of more partial hospitalization units/day treatment units. These settings provide comprehensive treatment during daytime hours for patients who have difficulty staying home, but may not need full inpatient hospitalization. They can also be used as “step down” units from inpatient hospitalization prior to discharge back to outpatient services. These units are less expensive than inpatient psychiatry units.

12. Provide option of group homes.

Group home settings can be very useful for individuals with chronic mental illnesses and for those with developmental disabilities. Generally these settings are more available for individuals with developmental disabilities. Greater availability of these settings, with proper regulation would also decrease inpatient hospital utilization rates.

The verdict on parity is still out, pending more experience in more stable settings. It appears though, that at least partial parity for some severe disorders does not increase costs significantly.

For years, research has demonstrated that specific types of psychotherapy services and family support services can decrease hospitalization rates, modify severity of illness, and enhance compliance with medication in many individuals with severe and chronic mental illnesses. Medicaid drug formularies and Medicaid capitation may decrease costs to some extent, however, other types of interventions show demonstrated abilities to decrease hospitalization, and promote better functioning in individuals with chronic mental illness. Although capitation for Medicaid mental health care is supposed to lead to improvement in care for these individuals and decreased costs, community mental health centers may be de-emphasizing these effective therapies. Although the state can claim that these choices are made locally, community mental health centers appear to have no choice other than cutting people and programs due to their cost structures. This may well be a false economy since there is every reason to expect that it will result in increases in dysfunction and exacerbated longer-term costs. Certainly, the literature points to the conclusion that decreases in support for families caring for individuals with chronic mental illnesses, and fewer support mechanisms for these individuals leads to increased medication costs and increases in hospitalization rates.

The history of mental health policy in this state demonstrates that policy is often made with little regard for research findings and there is little to no effort at systematic evaluation to determine what effects policy changes have on costs or level of functioning of affected individuals.

Certainly, the literature points to the conclusion that decreases in support for families caring for individuals with chronic mental illnesses, and fewer support mechanisms for these individuals leads to increased medication costs and increases in hospitalization rates.

APPENDICES

The American Academy of Pediatrics has looked at this issue from the child adolescent treatment need perspective. A portion of their recommendations have merit for Michigan. (American Academy of Pediatrics).

Parity should be established between medical health services and mental and behavioral health and substance abuse services.

The State Children's Health Insurance Program (SCHIP), which has provided additional resources for children's health care and has allowed for flexibility in the distribution of resources, should be supported and expanded to include coverage for mental and behavioral health and substance abuse services.

The number of qualified child mental health and substance abuse clinicians should be increased through support for training programs, better recruitment into these programs, and job incentives.

Competent, licensed providers with training and expertise in providing services to children should be equally included on panels, without limitations to specific disciplines.

Professionals need to be accessible and available to families within a reasonable distance and time frame.

Services provided by clinicians in alternative sites, such as schools, homes, and centers, must be reimbursed.

The processes required for children and adolescents to receive mental and behavioral health and substance abuse services should be simplified, shortened, and unified. For clinicians, this should include a universal credential verification process and a universal treatment authorization form. For families, it should include a simplified authorization and appeals process.

There should be no exclusions for diagnostic categories, chronic disorders, and preexisting conditions (chronic illness and developmental disabilities).

Reimbursements need to compensate clinicians adequately for the services provided.

Administrative practices need to be revised to reduce the practitioner's administrative burden.

REFERENCES

- ¹ Mental Health: A Report of the Surgeon General. Rockville MD. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999
- ² Murry CJL, Lopez AD (Eds) 1996 The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Cambridge, MA. School of Public Health
- ³ Robins LN, Regier DA. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York. Free Press
- ⁴ Kessler RC, Burglund PA, Zhao S, Leaf P, Kouzis AC, Bruce ML, Friedman RM, Grossier RC, Kennedy C, Narrow WE, Kuehnel TG, Laska EM, Manderscheid RW, Rosenheck RA, Santoni TW, Shneier M. The 12-month prevalence and correlates of serious mental illness, In Manderscheid RW, Sonnenschein MA. (Eds) Mental Health, United States, 1994(DHHA Publication No. (SMA) 96-3098, pp 59-70). Washington DC: US Government Printing Office.
- ⁵ Buck JA, Teich JL, Bae J, Dilonardo J. Mental health and substance abuse services in ten state medicaid programs. Administration and Policy in Mental Health, Jan, 2001
- ⁶ Brandenburg NA, Friedman RM, Silver SE. The epidemiology of childhood psychiatric disorders: prevalence findings from recent studies. Journal of the American Academy of Child and Adolescent Psychiatry 1990;29;76-83
- ⁷ Michigan In Brief, 1998-1999, 6th Edition, Public Sector Consultants Inc.
- ⁸ (An independent evaluation by the Department of Community health concluded the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were \$
- ⁹ Bird CD, Dempsey P, Harteley D. Addressing mental health workforce needs in underserved rural areas: accomplishments and challenges. Working Paper #23. Maine Rural Health Research Center Edmund S Muskie School of Public Service University of Southern Maine October 2001
- ¹⁰ Otten, Allen. Mental Health Parity: What Can it Accomplish in a Market Dominated by Managed Care? Milbank Memorial Fund, June, 1998
- ¹¹ National Alliance for the Mentally Ill. Mental Health Parity Laws by State. insure.com website,2000
- ¹² Insurance Carrier/Health Plan Views on Impact of New Hampshire Parity Legislation: Submitted to: The National Alliance for the Mentally Ill By: The Lewin Group, Inc. April 1997
- ¹³ Sturm R. State Parity Legislation and Changes in Mental Insurance and Perceived Access to Care Among Individuals With Mental Illness: 1996-1998 Journal of Mental Health Policy and Economics, 3:209-213, 2000
- ¹⁴ Holahan J, Rangarajan S, Schirmer M. Managed Medicaid Care Payment Methods and Capitation Rates: Results of a National Survey. The Urban Institute, May, 1999

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Co-Authors

Nigel Paneth, M.D., M.P.H

Ewen C.D. Todd, Ph.D.

Oliver Hayes, D.O., M.P.H., F.A.C.E.P., F.A.C.O.E.P.

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William Strampel, D.O.

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Jed Magen, D.O.

Co-Authors:

Carol Barrett, Ph.D.

Maureen A. Mickus, Ph.D.

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Author:

Marilyn Rothert, Ph.D., R.N., F.A.A.N.

Co-Authors:

Teresa Wehrwein, Ph.D., R.N., C.N.A.A.

Judith Andre, Ph.D.

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Grace Kreulen, Ph.D., R.N.

Co-Authors:

Mary Noel, M.P.H., Ph.D., R.D.

James Pivarnik, Ph.D.

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Author:

Vence L. Bonham, J.D.

Co-Author:

David R. Nerenz, Ph.D.

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Author:

Maureen A. Mickus, Ph.D.

Co-Authors:

Andrew J. Hogan, Ph.D.

Clare C. Luz, Ph.D.

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INSTITUTE
for Health
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David R. Nerenz, Ph.D., Director
Michigan State University
D132 West Fee Hall
East Lansing, MI 48824
Phone: 517-432-4325 Fax: 517-353-4701
Web: <http://www.ihcs.msu.edu>

IPPSR
Institute for Public Policy & Social Research

Carol S. Weissert, Ph.D., Director
Michigan State University
321 Berkey Hall
East Lansing, MI 48824-1111
Phone: 517-355-6672 Fax: 517-432-1544
Web: <http://www.ippsr.msu.edu>

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