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Community Mental Health Services in Michigan

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Introduction

Major changes have occurred within Michigan's public mental health system during the past two decades. The Mental Health Code has been significantly rewritten. The Department of Community Health (DCH) was established by an Executive Order merging the former Departments of Mental Health and Public Health with Medical Services. The DCH implemented the Managed Specialty Services and Supports Program for the delivery of specialty mental health, developmental disability, and substance abuse services.

This publication, *Community Mental Health Services in Michigan*, will discuss the constitutional, statutory, and federal authorization for the delivery of community mental health services, organizational structure of community mental health services programs (CMHSPs) and prepaid inpatient health plans (PIHPs), mental health services provided by CMHSPs and PIHPs, powers and duties of CMHSPs boards, permissive activities of CMHSPs, financial liability of the county and state for CMHSPs, and funding methodology for PIHPs.

This publication also discusses appropriations for Medicaid and non-Medicaid services provided by CMHSPs and PIHPs for the past ten years, highlighting the major components of the appropriation line item changes from previous fiscal years.

Constitutional, Statutory, and Federal Authorization for the Delivery of Community Mental Health Services

Article IV, Section 51 of the **Michigan Constitution of 1963** states that the public health and welfare of the people are matters of primary public concern and requires the Legislature to pass suitable laws for the protection and promotion of public health.

Article VIII, Section 8 of the **Michigan Constitution of 1963**, as amended on December 19, 1998, requires that institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled always be fostered and supported. The 1998 amendment changed the term "handicapped" to "disabled".

In conjunction with provisions of the **Michigan Constitution**, the **Mental Health Code of 1974** as amended (**MCL 330.1001 - 330.2106**), requires the following of the DCH:

- ❖ Continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state;
- ❖ Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance;
- ❖ Give priority to services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability;
- ❖ Promote and maintain an adequate and appropriate system of community mental health services programs (CMHSPs) throughout the state;
- ❖ Shift primary responsibility for the direct delivery of public mental health services from the state to a CMHSP whenever a CMHSP has demonstrated a willingness and capacity to assume those responsibilities; and
- ❖ Financially support CMHSPs.

The **Mental Health Code** also requires the following of CMHSPs:

- ❖ Provide a comprehensive array of mental health services, appropriate for individuals, regardless of their ability to pay, and
- ❖ Provide services to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability.

The **Social Welfare Act of 1939** as amended (**MCL 400.109f - 400.109g**) requires:

- ❖ The DCH to support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance abuse disorder;
- ❖ Medicaid-covered specialty services and supports to be managed and delivered by specialty prepaid health plans (oftentimes referred to as prepaid inpatient health plans – PIHPs) chosen by the DCH, in consultation with a Specialty Services Panel created in Section 109g (a panel that was abolished in 2007 with its power and duties transferred to DCH);
- ❖ Specialty and support services be "carved out" from basic Medicaid health care benefits; and
- ❖ Specialty prepaid health plans to be considered managed care organizations as described in Title XIX of the Social Security Act.

Congruent with provisions of the **Social Welfare Act**, Section 232b of the **Mental Health Code (MCL 330.1232b)** requires the DCH to establish standards for CMHSPs designated as specialty prepaid health plans (hereafter referred to as PIHPs) which reference applicable federal regulations and specify state requirements. In essence, PIHPs are either CMHSPs or affiliations of CMHSPs that receive capitated payments for Medicaid mental health and substance abuse covered services.

The Centers for Medicare and Medicaid Services (CMS) approval of Sections 1915(b) and 1915(c) waivers provides federal authorization for PIHPs to manage the Medicaid Specialty Services and Supports Program. The CMS approval of Section 1115 demonstration waiver provides federal authorization for PIHPs to manage the Medicaid Adult Benefits Waiver Program (ABW), a program for non-pregnant and childless adults with limited Medicaid benefits. Approved state plan amendments to the waiver requires existing ABW program participants to transition to Medicaid and the program to sunset on April 1, 2014.¹

¹ December 30, 2013 letter to Mr. Stephen Fitton, Director of Michigan Medicaid Services Administration, from the Department of Health and Human Services' Centers for Medicare and Medicaid Services

Organizational Structure of CMHSPs and PIHPs

Community mental health services programs are established under the Mental Health Code and organized in one of the following three ways:

- ❖ **County community mental health (CMH) agency** in which the procedures and policies for the organization are set by the county Board of Commissioners or counties Board of Commissioners;
- ❖ **CMH organization** in which two or more counties are organized under the Urban Cooperation Act (**MCL 124.501 - 124.512**); the public governmental entity is separate from the counties that established it; procedures and policies are set by the Board of the CMHSP; and
- ❖ **CMH authority** in which the separate legal public governmental entity is created under Section 205 of the Code (**MCL 330.1205**); the county CMH agency or CMH organization is certified by the DCH under Section 232a of the Code (**MCL 330.1232a**); and procedures and policies are set by the Board of the CMHSP.

There are currently 39 CMH authorities (including Detroit-Wayne County CMHSP which converted to an authority on October 1, 2013), 5 CMH agencies (Allegan County CMH Services, Lapeer County CMH Services, Macomb County CMH Services, CMH Services of Muskegon County, and CMH of Ottawa County), and 2 CMH organizations (Manistee-Benzie CMH d.b.a. Centra Wellness Network and Washtenaw Community Health Organization).

Prepaid inpatient health plans (PIHPs) are established through a procurement process completed by the DCH in which qualified CMHSPs were given initial consideration to operate as PIHPs for designated service areas. The approved plan submitted by the DCH to CMS indicated that a CMHSP must have at least 20,000 Medicaid beneficiaries ("covered lives") within their respective catchment area to be eligible to apply for designation as a PIHP. If CMHSPs did not meet the threshold of 20,000 Medicaid beneficiaries, they were able to combine with other CMHSPs and make a consolidated application for designation as a PIHP. The qualification for designation as a PIHP included certain administrative capabilities, cost parameters, service capacity, eligibility and access assurance, and enhancement of consumer opportunities.²

There were 18 PIHPs established throughout the state. Effective January 1, 2014, however, there are 10 PIHPs based on realignment of the PIHP system.

Mental Health Services Provided by CMHSPs and PIHPs

Pursuant to the Mental Health Code, mental health services offered and/or provided directly or under contract by CMHSPs are, at the minimum, to include the following:

- ❖ Crisis stabilization and response including a 24-hour, 7-day per week crisis emergency service;
- ❖ Identification, assessment, and diagnosis to determine the specific needs of the individual and development of an individual plan of services;
- ❖ Planning, coordination, and monitoring to assist the individual in gaining access to services;
- ❖ Specialized mental health treatment which includes therapeutic clinical interactions;
- ❖ Recipient rights services;
- ❖ Mental health advocacy;
- ❖ Prevention activities; and
- ❖ Other services approved by the DCH.

² MDCH FY 2010 Base Program Descriptions

Prepaid inpatient health plans, either directly or under contract, are required to offer the array of services identified above for CMHSPs to Medicaid beneficiaries of mental health services, and the following Medicaid specialty services and supports as outlined in the Department of Community Health's Medicaid Provider Manual³:

- ❖ Applied behavior analysis;
- ❖ Assertive community treatment;
- ❖ Behavior treatment review;
- ❖ Child therapy;
- ❖ Clubhouse psychosocial rehabilitation programs;
- ❖ Crisis interventions and residential services;
- ❖ Family therapy;
- ❖ Health and home-based services;
- ❖ Individual and group therapy;
- ❖ Inpatient psychiatric hospital admissions;
- ❖ Intensive crisis stabilization services;
- ❖ Intermediate care facility for individuals with mental retardation (ICF/MR) services;
- ❖ Medication administration and review;
- ❖ Nursing facility mental health monitoring;
- ❖ Occupational therapy;
- ❖ Outpatient partial hospitalization services;
- ❖ Personal care in licensed specialized residential setting;
- ❖ Physical therapy;
- ❖ Speech, hearing, and language;
- ❖ Targeted case management;
- ❖ Telemedicine;
- ❖ Transportation; and
- ❖ Treatment planning.

In broad terms, services provided to and/or received by individuals who meet the priority mental health needs identified in the Mental Health Code may be different for Medicaid beneficiaries and individuals who do not qualify for Medicaid. The Medicaid program is a joint federal-state funded program that pays for mental health services and entitles eligible individuals to certain services. Conversely, CMHSPs are contractually required to provide services to individuals not eligible for Medicaid to the extent general fund/general purpose (GF/GP) resources are available.

The most recent report from the DCH indicates that CMHSPs and PIHPs provided services to 242,884 individuals in FY 2011-12.⁴ Of this total, 176,196 individuals were eligible for Medicaid (a number in which an individual eligibility for programs can be counted more than once for also the following program eligibility categories or groups: Adoption Subsidy, Medicare, Supplemental Security Income (SSI), or Commercial Health Insurance). The CMHSPs and PIHPs provided services to 200,424 individuals in FY 2004-05.⁵ Of this total, 122,235 individuals were eligible for Medicaid. The growth in the number of individuals served has been driven by increased Medicaid eligibility.

³ MDCH, Medicaid Provider Manual, Mental Health/Substance Abuse, October 2013

⁴ Report for Section 404, Community Mental Health Services Programs Demographic and Cost Data, FY 2012

⁵ Report for Section 404, Community Mental Health Services Programs Demographic and Cost Data, FY 2005

Powers and Duties of CMHSPs Boards

The powers and duties of the boards of CMHSPs are specified in the Mental Health Code. They include:

- ❖ Conduct an annual needs assessment to determine the mental health needs of the county residents and identify public and nonpublic services necessary to meet those needs;
- ❖ Annually review and submit a needs assessment report, annual plan, and request for new funds for the CMHSPs to DCH;
- ❖ In the case of a county CMH agency, obtain approval of its needs assessment, annual plan and budget, and request for new funds from the county Board of Commissioners; and in the case of a CMH organization or CMH authority, provide a copy of its need assessment, annual plan, and request for new funds to the county Board of Commissioners creating the organization or authority;
- ❖ Annually approve the CMHSP operating budget;
- ❖ Take necessary and appropriate action to secure private, federal, and other public funds to support the CMHSP;
- ❖ Approve and authorize all contracts for the provision of services; and
- ❖ Review and evaluate the quality, effectiveness, and efficiency of services provided by CMHSPs.

Permissive Activities of CMHSPs

In accordance with provisions of the Mental Health Code, CMHSPs are permitted to do the following:

- ❖ Carry forward any surplus of revenue over expenditures under a capitated managed care system;
- ❖ Carry forward the operating margin (excess of state revenue over state expenditures for a fiscal year exclusive of capitated payments) up to 5% of the CMHSP's state share of the operating budget for the fiscal years ending September 30, 2009, 2010, and 2011 (an expired provision in law that is currently included in CMHSPs' contracts⁶); in the case of CMH authorities, the carry forward authorization is in addition to reserve accounts to cover vested employee benefits, depreciation of capital assets, and expected future expenditures for an organization retirement plan;
- ❖ Pursue, develop, and establish partnerships with private individuals or organizations to provide mental health services; and
- ❖ Share the costs or risks, or both, of managing and providing publicly funded mental health services with other CMHSPs.

Financial Liability of County and State for CMHSPs

The county is financially liable for 10% of the "net cost" of any service that is provided by DCH, directly or by contract, to a resident of that county. "Net cost" is defined as the operating cost of providing the service minus that part paid for with federal and private funds and the amount received by the state as reimbursement from those individuals and insurers who are financially liable for the cost of services. This provision in law does not apply to family support subsidies (monthly payments to income-eligible families with a child under age 18 living at home who is severely mentally impaired, severely multiply impaired, or autistic). Nor does this provision apply to services provided to an individual under a criminal sentence to a state prison, a criminal defendant determined incompetent to stand trial, or individuals acquitted of a criminal charge by reason of insanity.

⁶ 7.7.1.1 of MDCH/CMHSP Managed Mental Health Supports and Services Contracts: FY 14

The state is required to pay 90% of the annual “net cost” of a CMHSP, a requirement subject to the availability of funds appropriated by the Legislature for this purpose. “Net cost” means CMHSPs expenditures eligible for state financial support and approved by DCH that are not paid for by federal and state funds, or reimbursements from individuals and insurers who are financially liable for the cost of services. This statutory requirement does not apply to a CMHSP in the fiscal year after it becomes a CMH authority as the 10% local county match requirement changes subject to the availability of local and state funds. Nor does this provision apply to family support subsidies in which the state is required to pay for the subsidies.

Funding Methodology for PIHPs

The Prepaid Inpatient Health Plans (PIHPs) receive a capitation payment (fixed per person monthly rate payable) for Medicaid covered specialty mental health, developmental disability, and substance abuse services provided to individuals in a managed care environment. Medicaid managed care capitation payments are used by PIHPs and other managed care organizations such as health maintenance organizations (HMOs) to control the growth of mental health and physical health care costs rather than create savings.⁷ The capitation payment rates for PIHPs are required by the federal CMS to be actuarially sound – rates developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.

Milliman, Inc. was retained by the DCH to develop capitation rates for the Managed Specialty Services and Support Waiver for FY 2013-14. A letter from Milliman documented the rate methodology, illustrated an actuarially sound rate range, and provided the required certification regarding actuarial soundness.⁸

Factors used in determining FY 2013-14 monthly capitation payment rates for PIHPs were: health insurance claim assessment, age, gender, and geographic region for the Temporary Assistance for Needy Families (TANF) and Disabled, Aged, and Blind (DAB) populations. The capitation base rate/range for certain populations may differ between PIHPs based on historical revenue requirements to serve the enrolled Medicaid beneficiaries and estimated morbidity (frequency with which a disease appears in a population) variation outside of age and gender.

According to the DCH, DCH then determined the rate/point within that range that each PIHP will receive. In the past, some PIHPs received rates on the lower end of their individual ranges while others received rates on the higher end and, accordingly, there was no assurance of consistency in picking the point within the range for each individual PIHP. For the first two quarters of FY 2013-14, DCH identified a payment rate for each PIHP at the highest consistent percentile of the respective payment ranges in an effort to achieve greater equity within the amount appropriated for PIHPs capitation payments. The change has resulted in an increase or decrease in Medicaid revenue for PIHPs per member per monthly capitation payment rates (increase for 9 PIHPs and decrease for 9 PIHPs).⁹

The base capitation payment rates and methodology for PIHPs are being evaluated by actuaries. As noted in the 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans¹⁰, it is DCH's intent to re-develop rate structure, methodologies, and adjustors in order to increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on historic revenue and geographic regions. Public Act 59 of 2013, Section 504 of Article IV, establishes a Workgroup comprised of representatives of DCH, PIHPs, and CMHSPs to make recommendations on achieving more uniformity in capitation payments made to the PIHPs. The recommendations are to be provided to the House and Senate Appropriations Subcommittees on Community Health, House and Senate Fiscal Agencies, and State Budget Director by March 1, 2014.

⁷ 7.4.1.1. of MDCH/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY 14

⁸ September 24, 2013 letter to the Department of Community Health from Milliman, Inc.

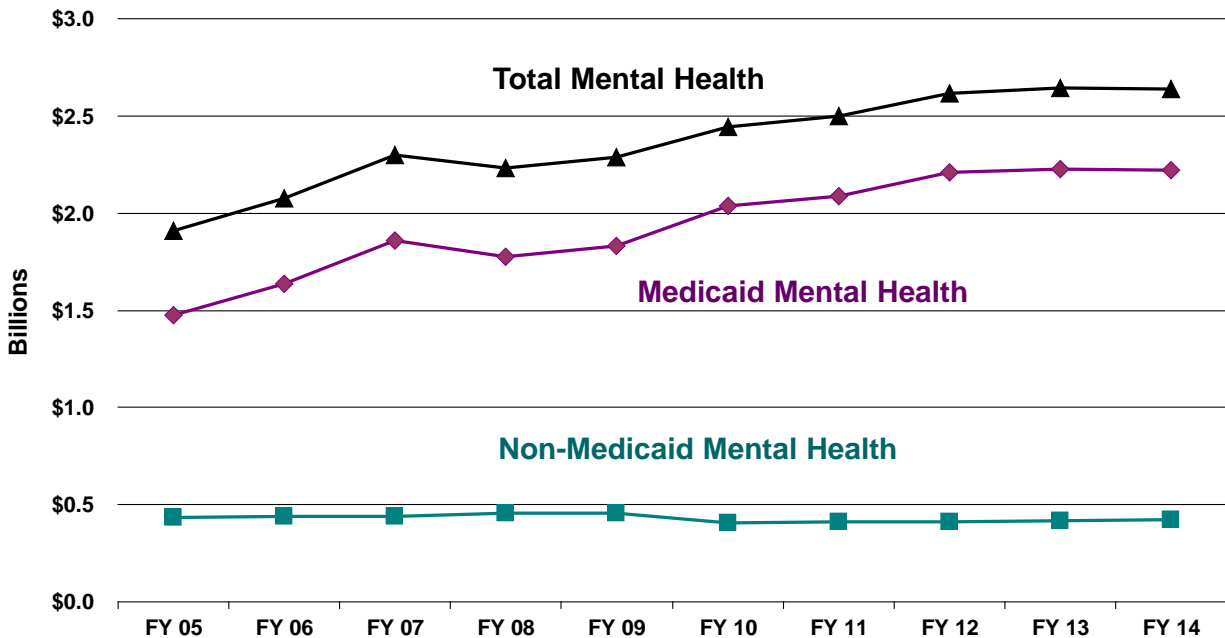
⁹ October 31, 2013, MDCH, Prepaid Inpatient Health Plans 1st Quarter Payments – Specialty Service and Supports Capitation Rates Fiscal Years 2013 and 2014

¹⁰ 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans, Michigan Department of Community Health Behavioral Health and Developmental Disabilities Administration, 2/6/2013

**Appropriations for Medicaid and Non-Medicaid
Services Provided by CMHSPs and PIHPs
FY 2004-05 Through FY 2013-14**

Since FY 2004-05, Medicaid mental health gross appropriations have increased by \$744.6 million (50.5%), non-Medicaid mental health gross appropriations have decreased by \$12.6 million (2.9%), and total mental health gross appropriations have increased by \$731.8 million (38.4%).¹¹ *The appropriations do not include enacted supplemental appropriations or appropriations included in the Medicaid Reform/Healthy Michigan Plan Legislation - Public Act 107 of 2013.*

Figure 1



Medicaid mental health appropriations in this publication represent funding for the following four appropriation line items:

- ❖ **Medicaid mental health services** - Medicaid managed care capitated funds for CMHSPs or PIHPs serving state residents in which mental health services are provided by CMHSPs or PIHPs, or contract with public or private agencies;
- ❖ **Medicaid adult benefits waiver** - funds provided to CMHSPs to provide limited mental health and substance abuse services to childless eligible adult; beneficiaries are paid under a prepaid capitation basis with CMHSPs and department-designated community mental health entities for substance abuse services;
- ❖ **Children's waiver home care program** - funds for home- and community-based services for eligible children with developmental disabilities that enables them to reside at home with their birth and adoptive families, and who would otherwise require institutional care; and
- ❖ **Children with serious emotional disturbance waiver** - funding that allows counties and CMHSPs to provide home- and community-based mental health services to eligible children with serious emotional disturbance, including a program with the Department of Human Services that provides services for abused and neglected children.

¹¹ House Fiscal Agency FY 2004-05 through FY 2013-14 Final Decision Documents for Department of Community Health

Non-Medicaid mental health appropriations in this publication represent funding for the following two appropriation line items:

- ❖ **Community mental health non-Medicaid services** - non-Medicaid funds provided to CMHSPs serving residents of the state who are not covered by Medicaid or who require services that are not benefits under the state Medicaid plan in which the mental health services are provided directly by CMHSPs, or by contract with public or private agencies; and
- ❖ **CMHSP, purchase of state services contracts** - funding that is used by CMHSPs to purchase state services for clients in their catchment areas or develop their own community alternatives to utilization of state-operated psychiatric hospitals. *(Funding is categorized and/or treated as local revenue when supporting the appropriations for state-operated psychiatric hospitals.)*

Table 1
Major Components of Medicaid and Non-Medicaid Mental Health Cumulative
Gross and GF/GP Appropriation Line Item Changes from Previous Fiscal Years
FY 2004-05 Through FY 2013-14

<u>Description</u>	<u>Gross Funding Amount</u>	<u>GF/GP Funding Amount</u>	<u>Gross Percentage of Major Components</u>	<u>GF/GP Percentage of Major Components</u>
Federal Medical Assistance Percentage Changes	(\$4,632,800)	(\$162,292,400)	(0.6)	(166.7)
Medicaid Eligibles Caseload Adjustments	\$368,675,100	\$134,730,800	51.1	138.4
Actuarially Sound Capitation Payment Rates For PIHPs	\$363,083,100	\$125,148,300	50.3	128.6
Changes in the Utilization of Days of Care at State Facilities by CMHSPs	\$1,343,300	(\$6,234,300)	0.2	(6.4)
Provider Tax, Use Tax, and Health Insurance Claim Assessment Revenue for PIHPs	(\$99,316,300)	(\$5,947,200)	(13.8)	(6.1)
New Medicaid Programs and Services for PIHPs and CMHSPs	\$74,228,900	(\$5,572,200)	10.3	(5.7)
Funding Changes for CMHSPs Non-Medicaid Programs and Services	\$88,477,700	\$75,609,500	12.3	78.7
Programs and Services Reductions for PIHPs and CMHSPs	(\$71,306,800)	(\$60,540,900)	(9.9)	(62.2)
Medicaid Mental Health-Related Program Endeavors Not Approved by the Federal Government	\$805,200	\$2,448,800	0.1	2.5
TOTAL	\$721,357,400	\$97,350,400		

Federal Medical Assistance Percentage Changes

As stated earlier in the section on mental health services provided by CMHSPs and PIHPs, the Medicaid program is a joint federal-state funded program that pays for mental health services and entitles eligible individuals to certain services. The federal government's share of a state's expenditures is called the federal medical assistance percentage (FMAP) rate. The remainder is referred to as the nonfederal share or state share.¹² Changes in the regular and enhanced FMAPs for Medicaid, State Children's Health Insurance Program (SCHIP) and American Recovery and Reinvestment Act of 2009 (ARRA) has an impact on Medicaid mental health-related funding. The regular FMAP increased from 55.89% to 66.39% from FY 2004-05 through FY 2012-13 and decreased to 66.32% in FY 2013-14. The enhanced FMAP for SCHIP which supported the Medicaid Adults Benefit Waiver Program from FY 2004-05 through FY 2009-10 increased from 69.12% to 74.23%. And, the enhanced FMAP for ARRA which supported the Medicaid mental health programs in FY 2009-10 and FY 2010-11 increased the regular FMAP rate from 63.19% to an average annualized rate of 71.24%.

All of the noted changes in the FMAP for Medicaid mental health appropriations have resulted in the following: a decrease of \$4.6 million in gross appropriations; an increase of \$159.0 million in federal revenue; an increase of \$1.4 million in state restricted revenue; an increase of \$72,100 in local revenue; and a decrease of \$162.3 million in general fund/general purpose appropriations.

Caseload Adjustments for Medicaid Eligibles

Caseload adjustments for those individuals eligible for Medicaid is a major component of Medicaid mental health related funding changes. From FY 2004-05 through FY 2013-14, \$368.7 million Gross (\$134.7 million GF/GP) has been appropriated for changes in the number of eligible Medicaid beneficiaries. The average monthly caseload for those individuals eligible for Medicaid mental health services during FY 2004-05 and FY 2012-13 were respectively 1,280,110 and 1,617,899 – an increase of 26.4% in the average monthly Medicaid caseload. This information is based on reports prepared by the DCH which notes PIHPs monthly capitation payments and eligibles.¹³

When Public Act 107 of 2013 (Enrolled House Bill 4714) becomes effective April 1, 2014, it is anticipated that more individuals with mental illness will qualify for Medicaid and be 100% federally covered until 2017 given the change to 133% of the federal poverty level as a determinant of Medicaid eligibility.

Actuarially Sound Capitation Payment Rate for PIHPs

As discussed earlier in the detail on the funding methodology for PIHPs, PIHP capitation payment rates are required by the federal CMS to be actuarially sound. From FY 2004-05 through FY 2013-14, \$363.1 million Gross (\$125.1 million GF/GP) has been appropriated for PIHPs to ensure that capitation payment rates are actuarially sound. The rate increase was 2.5% in FY 2004-05 and 1.25% in the current fiscal year. The average yearly rate increase over this ten year period is \$33.0 million Gross (\$11.4 million GF/GP).

¹² Congressional Research Service, Medicaid's Federal Medical Assistance Percentage (FMAP), FY 2014, January 30, 2013

¹³ Appropriation 02965 – Medicaid Mental Health Services, FY 2005 Projected Managed Care Payments
Appropriation 02965 – Medicaid Mental Health Services, FY 2013 Projected Managed Care Payments

Changes in the Utilization of Days of Care at State Facilities by CMHSPs

The days of care utilized by CMHSPs for their clients at state-operated facilities impacts the amount of funding received by this entity as well as PIHPs. Slightly more than \$1.3 million has been included in the budget for these purposes, except for FY 2007-08, FY 2010-11, FY 2011-12, and FY 2012-13 (fiscal years in which the DCH was examining and evaluating funding options for recognizing prior fiscal year changes in the utilization of days of care at state hospitals by CMHSPs or managing this type of adjustment through spending authorizations for state hospitals).

On the surface, the funding allocation and/or component may appear to be insignificant and not noteworthy; however, this type of adjustment has been primarily financed through the redirection of funds from other line items. In total, \$40.8 million GF/GP has been redirected from the CMHSP, Purchase of State Services Contracts and Community Mental Health Non-Medicaid Services appropriations. In addition, in FY 2009-10, the state realized GF/GP savings of \$6.2 million by "federalizing" earned days of care provided to clients at the former Mt. Pleasant Center for Individuals with Developmental Disabilities and establishing a specialized rate increase for the placement of those clients in the community. In the current fiscal year, almost \$9.0 million GF/GP has been redirected from the CMHSP, Purchase of State Services Contracts appropriation to the Community Mental Health Non-Medicaid Services appropriation. This budgetary change from the previous fiscal year recognizes the utilization of days of care at state facilities by CMHSPs from FY 2005-06 through FY 2010-11 and enables CMHSPs to provide services to individuals with mental illness who are not covered by Medicaid.

Provider Tax, Use Tax, and Health Insurance Claim Assessment Revenue for PIHPs

There have been a variety of assessments or revenue mechanisms developed for PIHPs (as well as other managed care organizations) to generate additional federal revenue for PIHPs and offset State GF/GP support that would otherwise be required to support Medicaid mental health programs. The assessments or mechanisms for PIHPs are and have been:

- ❖ 6.0% and 5.5% quality assurance assessment program fee on PIHPs, oftentimes referred to as either QAAP or the provider tax;
- ❖ 6.0% Use Tax on PIHPs, revenue which went to the State's General Fund; and
- ❖ 1.0% health insurance claim assessment (HICA) on claims paid by health insurance providers, a revenue replacement for the Use Tax which also goes to the State's General Fund.

The PIHP provider tax was terminated during 2009 because the Federal Deficit Reduction Act of 2005 changed provider class definition to include Medicaid and non-Medicaid managed care organizations. The Use Tax on PIHPs was repealed in 2011 as the tax was deemed at risk with the federal government and not considered a broad based tax. The health insurance claim assessment was instituted in 2011 to cover the loss of revenue from the 6.0% Use Tax.

The budgetary adjustments related to these assessments and revenue mechanisms for the noted Medicaid mental health appropriations resulted in a gross net decrease of \$99.3 million (\$5.9 million GF/GP). The adjustments include: an additional \$94.7 million Gross, in conjunction with corresponding reduction of \$38.7 million GF/GP, given the 6.0% provider tax on PIHPs; elimination of \$133.2 million Gross (\$45.1 million GF/GP) in use tax revenue anticipating a 1.0% HICA on PIHPs; and a reduction of \$69.4 million Gross (\$23.5 million GF/GP) due to the reversal of use tax revenue adjustments included in Public Act 278 of 2012 supplemental.

Funding for New Medicaid Initiated Programs and Services for PIHPs and CMHSPs

Very few Medicaid mental health-related programs and services have been initiated in the past ten fiscal years, with limited budget impact. Following is a description of these programs and services:

- ❖ In FY 2006-07, federal Medicaid funding was authorized for the Children with Serious Emotionally Disturbance Waiver Program that expanded coverage to 43 children with serious emotional disturbances and/or children who were chronically mentally ill. Services are provided to children less than 21 years old in the community rather than institutional settings and the GF/GP match for the federal funds are provided by CMHSPs. The waiver program was modified in FY 2009-10. Currently, this program has been implemented in 37 counties and 25 CMHSPs in which home- and community-based services are provided to 804 eligible children with serious emotional disturbance, including a program with the Department of Human Services that provides services for abused and neglected children – as referenced earlier in the description of this line item.
- ❖ The hospital reimbursement adjustor (HRA) payments to PIHPs were authorized for the Medicaid Mental Health Services line item in FY 2009-10. Similar to the case of regular hospital reimbursement adjustor payments made to Medicaid Health Plan Services, estimated payments from private inpatient psychiatric hospitals for mental health services are incorporated into the monthly capitation payments to PIHPs. These adjustor payments result in an increase in the amount of funding provided to PIHPs.
- ❖ A Department of Human Services (DHS) funded increase for an enhanced rate and incentive payment through PIHPs to serve abused and neglected children was implemented in FY 2012-13 given the approval of a state plan waiver amendment. The children must have a serious emotional disturbance, be eligible for Medicaid, be between the ages of 0 to 18, served in the DHS Foster Care System or Child Protective Services, and meet one of the following service criteria in the eligible month: wraparound services, home-based services, or 2 or more state plan mental health services covered under the Specialty Services and Supports Waiver, excluding one-time assessments.
- ❖ Three behavioral health homes demonstration projects have been authorized funding in the current fiscal year. The projects have been implemented for the purposes of ensuring better coordination of physical and behavioral health care for Medicaid beneficiaries with chronic conditions such as asthma, heart disease, obesity, mental condition, or substance abuse disorder.

Funding for the noted Medicaid programs and services has resulted in a gross increase of \$74.2 million and a reduction of \$5.6 million GF/GP. Most of the funding increase is attributable to the hospital reimbursement adjustor payments for PIHPs. Also, included in the total funding change is \$4.1 million Gross (\$0 GF/GP) that was allocated for the Children's Waiver Home Care Program in recognition of CMHSPs administrative costs and adjustor payments (additional federal Medicaid dollars partially covering the cost of waiver services that were previously funded with CMHSPs non-Medicaid resources).

Funding Changes for CMHSPs Non-Medicaid Programs and Services

Most of the funding changes for CMHSPs Non-Medicaid programs and services, excluding changes in the utilization of days of care by CMHSPs for clients at state-operated facilities and program reductions, is attributable to the following items:

- ❖ Transfer of funding to CMHSPs for expired state-administered residential leases;
- ❖ Financing economic adjustments related to state-operated facilities;
- ❖ Financing the inflationary adjustments for pharmacy costs at state facilities;
- ❖ Employee-related savings and consolidation of operations at state facilities;
- ❖ Wage increases for direct care workers in community residential settings (which also impacted the Medicaid Mental Health Services appropriation); and
- ❖ Replacement of lease/rental revenue, base cost adjustments for state facilities, and Mt. Pleasant Center certification costs.

The Community Residential and Support Services appropriation finances the costs of community residential leases for individuals under the Department of Community Health's responsibility. Once the lease arrangements have expired for the state, the financial responsibility for them is transferred to CMHSPs. From FY 2003-04 through the current fiscal year, \$2.8 million GF/GP has been transferred to CMHSPs for an estimated 95 expired state-administered residential leases.

Only GF/GP revenue supports the CMHSP, Purchase of State Services Contracts line item which finances economic adjustments related to state-operated facilities such as: wage and salary adjustments for nonexclusively represented and unionized employees; adjustments for employees defined benefit and contribution retirement costs as well as insurance costs; other post-employment benefit costs for employees; patients food costs; and gas, fuel, and utility costs. Since FY 2003-04, \$62.0 million GF/GP has been allocated from the CMHSP, Purchase of State Services Contracts line item for state facilities economic adjustments.

The CMHSP, Purchase of State Services Contracts line item also finances inflationary adjustments for pharmacy costs at state-operated facilities. The inflationary adjustment has ranged from 22.8% to 3.0% and totals \$2.4 million GF/GP. Furthermore, employee-related savings of \$12.0 million GF/GP have been achieved through early retirement incentives for employees, elimination of funded and vacant FTE positions, and the consolidation of operations at state facilities.

Wage increases for direct care workers in community residential settings were financed in the FY 2005-06, FY 2007-08, and FY 2009-10 budgets. As noted in Section 404 of Article IV, Public Act 59 of 2013, direct care workers are considered employees in local residential settings and other settings where skill building, community living supports and training, and personal care services are provided by CMHSPs or PIHPs directly or through contracts with provider organizations. During this time period, \$26.7 million Gross (\$12.3 million GF/GP) was specifically allocated for wage increases for direct care workers.

Miscellaneous funding adjustments for CMHSP Non-Medicaid Programs and Services include the replacement of state restricted revenue that was no longer available with GF/GP, funds to support base costs at state-operated facilities, funding to ensure Medicaid certification of Mt. Pleasant Center for Persons with Development Disabilities. The adjustments for these purposes total \$6.5 million Gross (\$8.1 million GF/GP).

Program and Service Reductions for PIHPs and CMHSPs

From FY 2009-10 through FY 2013-14, there have been measures included in the budgets to reduce funding for Medicaid and Non-Medicaid programs and services provided by PIHPs and CMHSPs and/or redirect funding for new program initiatives. Those measures undertaken include:

- ❖ Annualization of the Executive Order 2009-22 reduction of \$10.0 million for non-Medicaid services provided by CMHSPs and other administrative and service capacity reductions;
- ❖ Elimination of the Transitional Medical Assistance (TMA) Plus program which provided health care coverage including mental health and substance abuse services to families with incomes up to 185% of the federal poverty level who are transitioning off of Medicaid and are no longer eligible for regular TMA;
- ❖ A reduction and/or freeze in the enrollment of individuals in the federal Home and Community-Based Services Habilitation and Supports Waiver program which provides community-based services to individuals with developmental disabilities who would otherwise require the level of services provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);
- ❖ Reduction in funding for the Children's Waiver Home Care program; and
- ❖ Redirection of funds to the Behavioral Health Program Administration appropriation (formerly the Mental Health/Substance Abuse Program Administration appropriation) to finance a jail diversion programs initiative and project that provides a safety net for individuals with developmental disabilities who are at risk of placement in licensed adult foster care facilities or being admitted to hospital inpatient units.

The programs and services reductions for PIHPs and CMHSPs total \$71.3 million Gross (\$60.5 million GF/GP).

Medicaid Mental Health-Related Funding Endeavors Not Approved by the Federal Government

As a means of capturing additional federal and state restricted revenue, reducing GF/GP support for mental health funded program, and increasing payment rates for PIHPs, some endeavors were undertaken by the DCH in FY 2004-05 through FY 2008-09 that were not successful due to lack of approval by the federal government. The endeavors include:

- ❖ Replacing \$3.5 million in GF/GP with state restricted revenue by taxing group home beds for individuals with developmental disabilities;
- ❖ Capturing \$14.8 million in additional QAAP and Medicaid revenue and saving \$5.3 million in GF/GP by transferring anti-psychotic pharmaceutical costs of PIHP capitation payments; and
- ❖ Transferring \$149.1 million Gross (\$65.1 million GF/GP) for pharmaceutical costs to PIHP capitation payments.

The unsuccessful endeavors resulted in a net increase of \$805,200 Gross (\$2.4 million GF/GP) due to changes in the federal medical assistance percentages and QAAP.

Conclusion

As discussed in previous sections, highlighted major components of Medicaid and non-Medicaid mental health cumulative line item changes during the past ten years have resulted in an increase of \$721.4 million Gross (\$97.4 million GF/GP). The increase in Gross appropriations has been driven mainly by increases in Medicaid-eligibles caseload, actuarially sound capitation payment rate adjustments, new Medicaid initiated programs and services for PIHPs and CMHSPs, and funding changes for CMHSPs non-Medicaid programs and services. General fund increases for those factors have been partially offset by increases in the Federal Medical Assistance Percentage match rate, and program and service reductions for PIHPs and CMHSPs.

The state of Michigan is transitioning into a system in which PIHPs are realigned and funds are distributed to departmentally-designated community mental health entities responsible for a continuum of substance abuse prevention, education, and treatment. Michigan is also in the process of implementing an integrated care for individuals eligible for Medicare and Medicaid demonstration project in four regions of the state in which PIHPs will be expected to cover behavioral health and habilitative services for individuals with mental illness, developmental disabilities, or substance use issues. Implementation of the Medicaid reform legislation, Public Act 107 of 2013, will also result in more individuals with mental illness qualifying for Medicaid and being 100% federally covered until 2017. These systematic changes will have a profound impact on Medicaid and non-Medicaid funding allocations for PIHPs and CMHSPs.

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NOTE: This report was written by Margaret Alston, Senior Fiscal Analyst. Kathryn Bateson, Administrative Assistant, prepared the report for publication. We appreciate the assistance provided by the Department of Community Health in providing information utilized in this report. The House Fiscal Agency is solely responsible for the content of the report.



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