



Budget Briefing: HHS - Medical Services and Behavioral Health

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Briefing Topics

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 - Traditional Medicaid Program
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Medical Services and Behavioral Health

This is one of three briefings about the Department of Health and Human Services (DHHS) budget. See also briefings on Human Services and Public Health and Aging and Adult Services.

Medical Services

- The traditional Medicaid program is a joint federal-state health care program for low-income families, children, and disabled individuals
- Medicaid Program was expanded to include non-disabled, childless adults through the Healthy Michigan Plan beginning in 2014
- Also supports Children's Special Health Care Services, Federal Medicare Pharmaceutical Program, and MIChild
- Programs are governed through a combination of federal law and regulations, the Social Welfare Act, annual budget boilerplate language, and Michigan's Medicaid State Plan

Behavioral Health

- The Michigan Constitution (Article VIII, Section 8) states that institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported
- Behavioral health services are governed by the state's Mental Health Code (1974 PA 258, as amended) and federal regulations
- State also funds services for non-Medicaid-eligible individuals through local community mental health programs, and operates five psychiatric facilities

Key Budget Terms

Fiscal Year: The state's fiscal year (FY) runs from October to September. FY 2017-18 is October 1, 2017 through September 30, 2018.

Appropriation: Authority to expend funds. An appropriation is not a mandate to spend. Constitutionally, state funds cannot be expended without an appropriation by the Legislature.

Line Item: Specific appropriation amount in a budget bill which establishes spending authorization for a particular program or function.

Boilerplate: Specific language sections in a budget bill which direct, limit, or restrict line item expenditures, express legislative intent, and/or require reports.

Lapse: Appropriated amounts that are unspent or unobligated at the end of a fiscal year. Appropriations are automatically terminated at the end of a fiscal year unless designated as a multi-year work project under a statutory process. Lapsed funds are available for expenditure in the subsequent fiscal year.

Note: Unless otherwise indicated, historical budget figures in this presentation have not been adjusted for inflation.

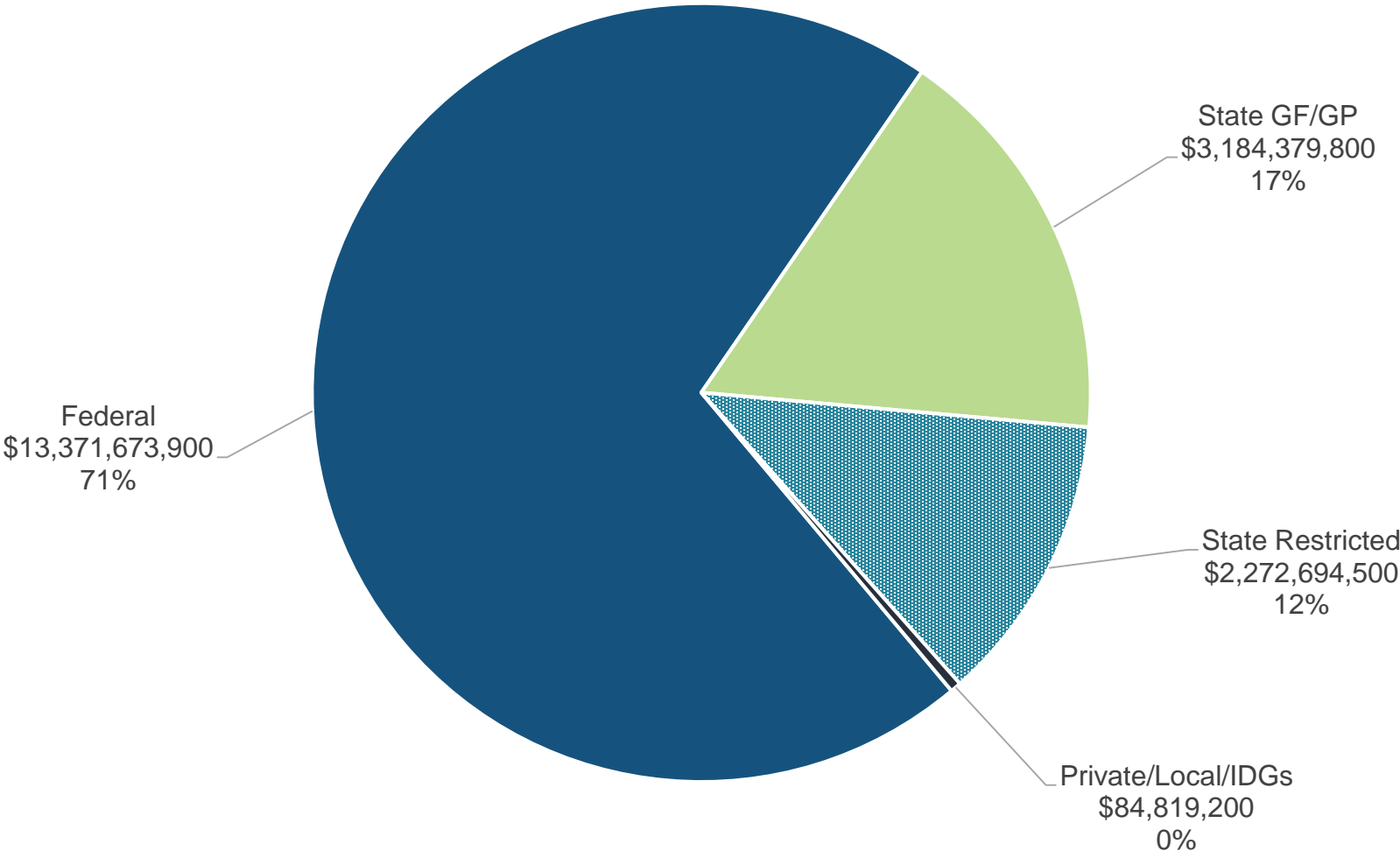
Funding Sources

FY 2017-18 Medical Services and Behavioral Health Budget

Fund Source	Funding	Description
Gross Appropriations	\$18,913,567,400	Total spending authority from all revenue sources
Interdepartmental Grants (IDG) Revenue	0	Funds received by one state department from another state department, usually for services provided
Adjusted Gross Appropriations	\$18,913,567,400	Gross appropriations excluding IDGs; avoids double counting when adding appropriation amounts across budget areas
Federal Revenue	13,371,673,900	Federal grant or matching revenue; generally dedicated to specific programs or purposes
Local Revenue	79,599,500	Revenue received from local units of government for state services
Private Revenue	5,219,700	Revenue from individuals and private entities, including payments for services, grants, and other contributions
State Restricted Revenue	2,272,694,500	State revenue restricted by the State Constitution, state statute, or outside restriction that is available only for specified purposes; includes most fee revenue
State General Fund/General Purpose (GF/GP) Revenue	\$3,184,379,800	Unrestricted revenue from taxes and other sources available to fund basic state programs and other purposes determined by the Legislature

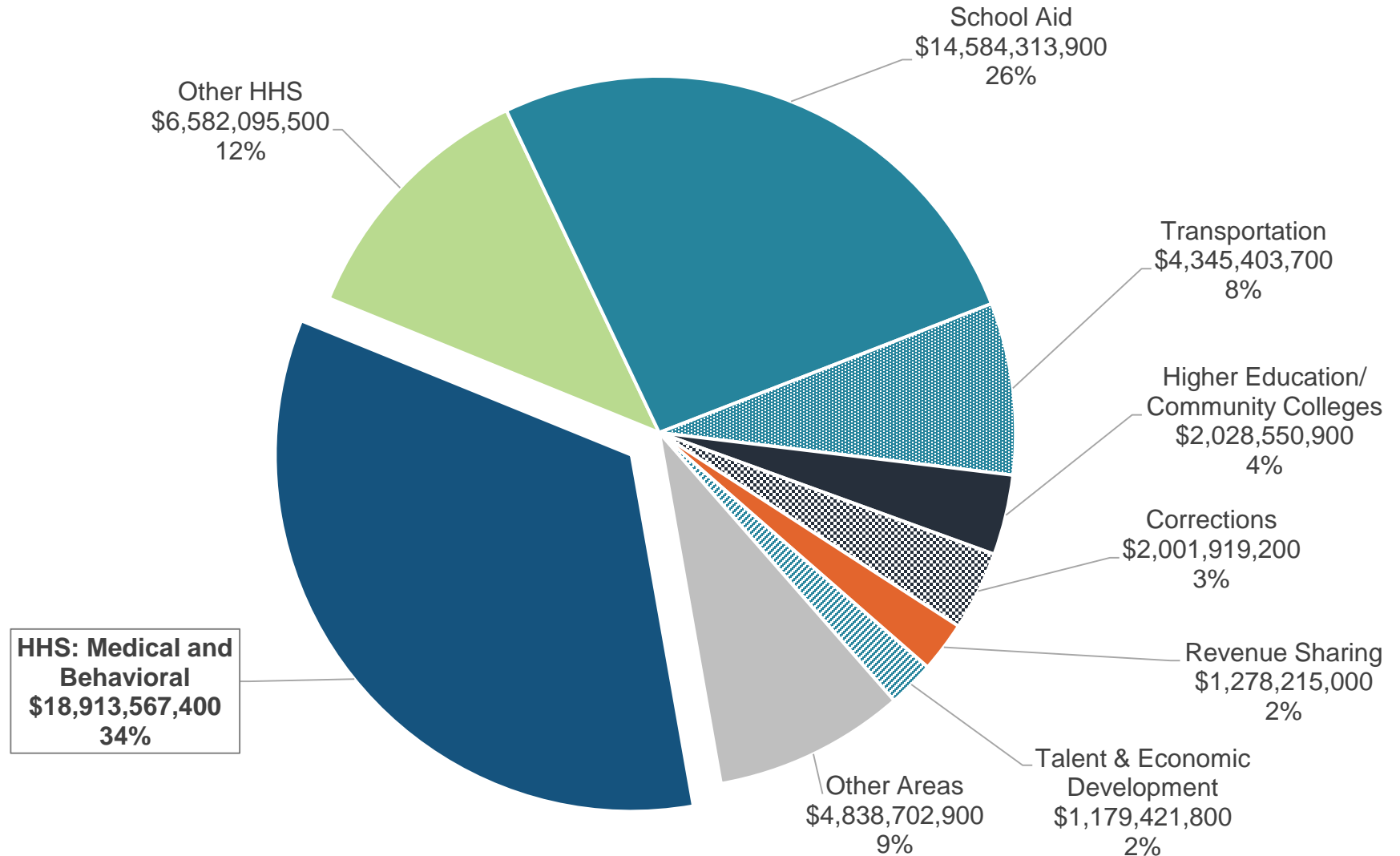
FY 2017-18 Fund Sources

71% of the **\$18.9 billion** Medical Services and Behavioral Health budget is funded by federal revenue, almost exclusively Medicaid and Healthy Michigan Plan matching funds.



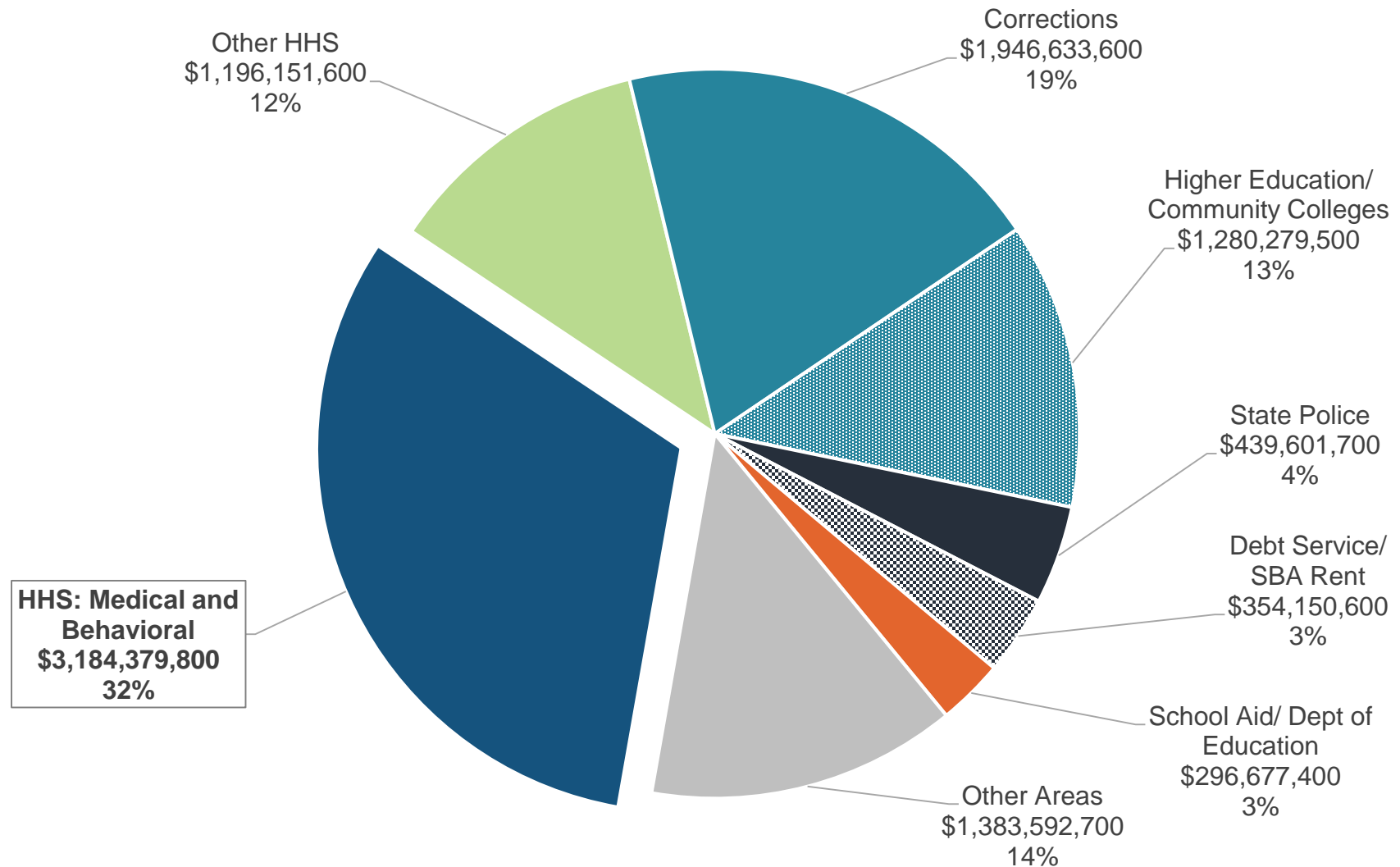
Medical and Behavioral Health Share of Total State Budget

Medical and Behavioral Health Services represent about one-third of the **\$55.8 billion** state budget (adjusted gross) for FY 2017-18.



Medical and Behavioral Health Share of Total GF/GP Budget

Medical and Behavioral Health Services also represent about one-third of the state's **\$10.1 billion** GF/GP budget for FY 2017-18.



Appropriation Areas

Medical Services and Behavioral Health Appropriation Areas

Administration of the Medicaid, Children's Special Health Care Services (CSHCS), MIChild, and Behavioral Health programs, including the Electronic Health Records Program

Medical services through the traditional Medicaid program, including both managed care payments and fee-for-service payments. Includes long-term and integrated care, home- and community-based waiver programs, provider-funded Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, Medicare premium payments, Medicare pharmaceutical "clawback" costs, CSHCS, and the MIChild program

Medical services through the Healthy Michigan Plan (HMP)

Special payments made for Special Medicaid Reimbursement to various health providers, GF/GP-funded DSH, School-Based Services, and the Dental Clinic Program

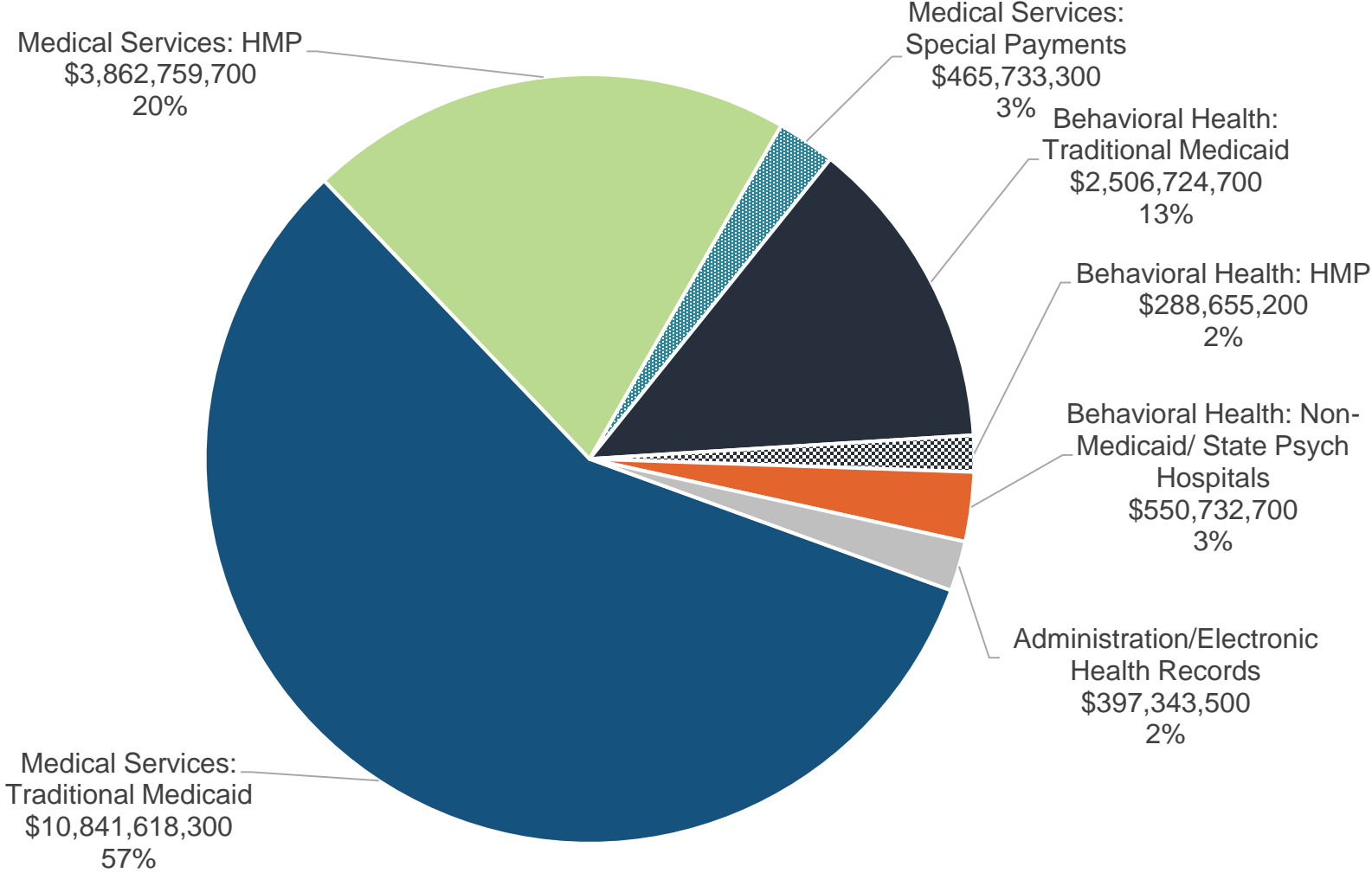
Behavioral health services through the traditional Medicaid program, including mental health services, substance abuse disorder services, children's waiver programs, and autism services

Behavioral health services through the HMP

Non-Medicaid Behavioral Health and State Psychiatric Hospitals

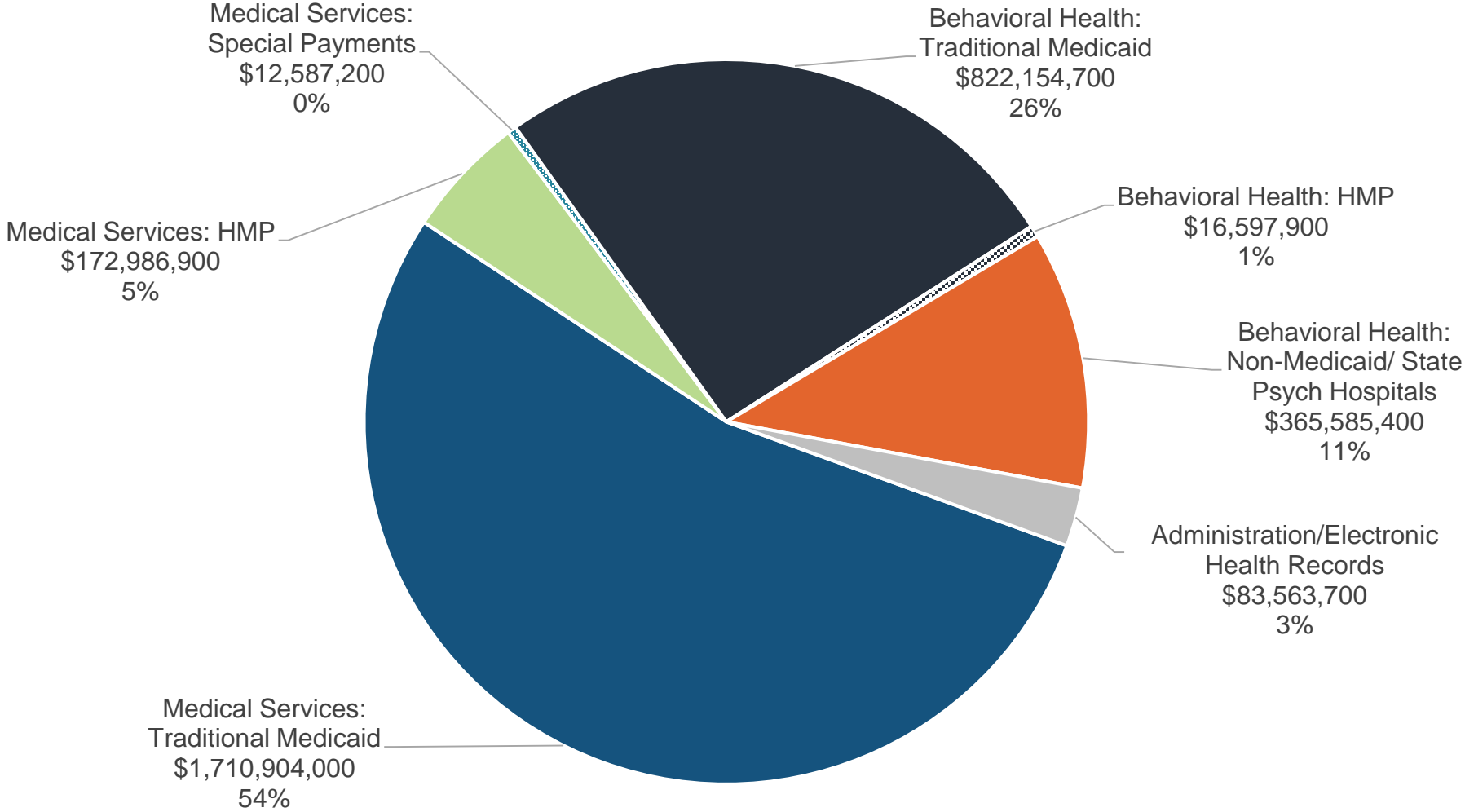
FY 2017-18 Gross Appropriations

73% of the \$18.9 billion Medical Services and Behavioral Health budget supports the Traditional Medicaid program. Another 22% supports the Healthy Michigan Plan.



FY 2017-18 GF/GP Appropriations

GF/GP funds (totaling **\$3.2 billion**) are more heavily concentrated in behavioral health and state psychiatric hospitals, and less heavily concentrated in Healthy Michigan Plan.



Major Budget Topics

Traditional Medicaid Program

Medicaid Eligibility

- States have the flexibility to establish income eligibility standards within federal standards
- Current net income eligibility standards (not including Healthy Michigan Plan):
 - Families receiving Family Independence Program cash assistance: 49% of the federal poverty level (FPL)
 - Aged, blind, and disabled individuals receiving Supplemental Security Income (SSI): 75% of FPL
 - Elderly and disabled individuals: up to 100% of FPL
 - Children under 18 in families: up to 160% of FPL
 - Pregnant women and newborn children: up to 195% of FPL
 - MIChild: up to 212% of FPL
 - Individuals needing long-term care services: up to 222% of FPL (or 300% of SSI)
 - Medically needy individuals with income or resources above regular financial eligibility levels

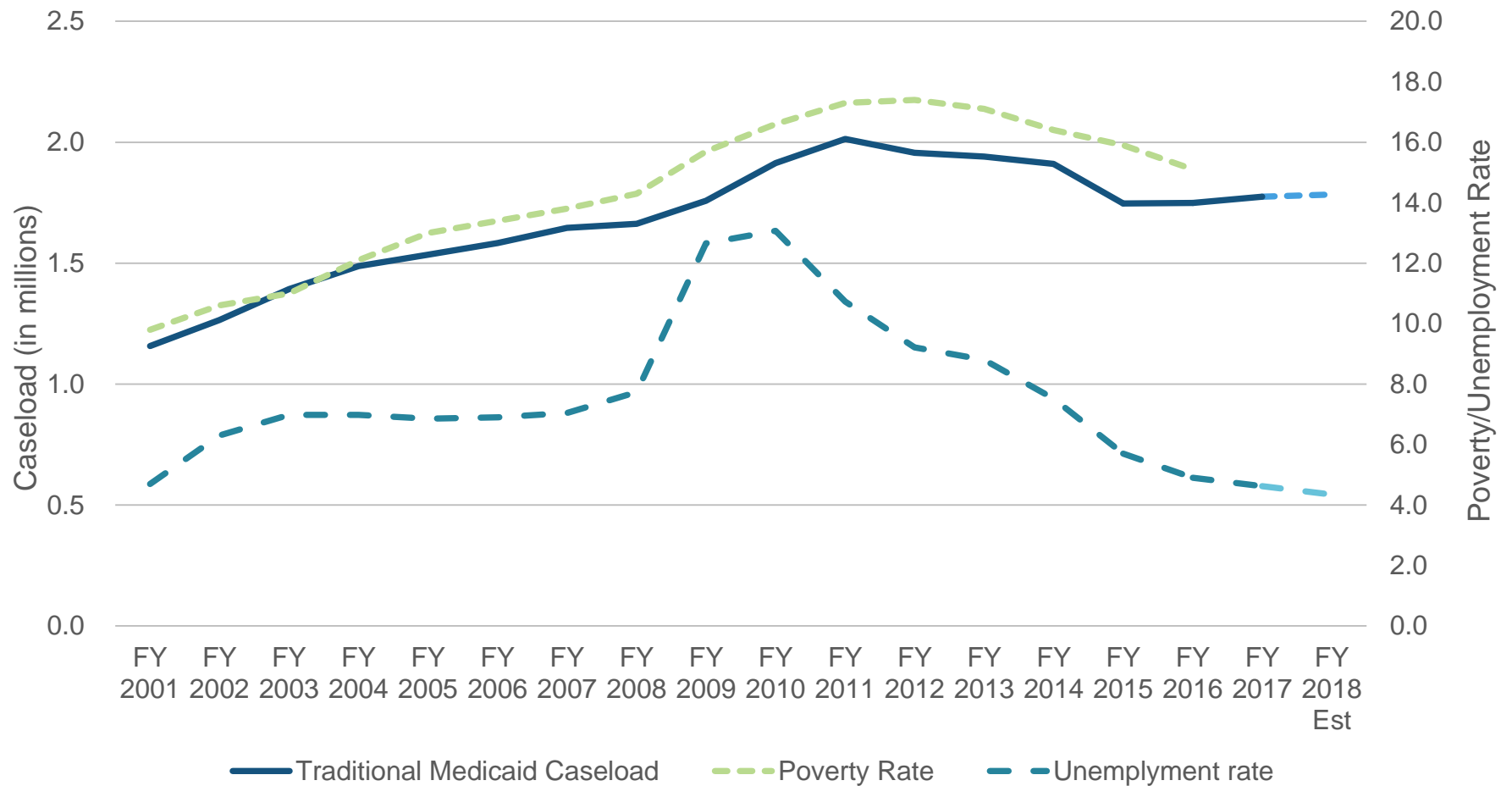
Medicaid Eligibility

2018 Federal Poverty Level Examples					
% of FPL	Eligibility Group	Individual	Family of 2	Family of 3	Family of 4
100%	Elderly/disabled	\$12,140	\$16,460	\$20,780	\$25,100
133%	Healthy Michigan Plan	16,146	21,892	27,637	33,383
160%	Children under 18	19,424	26,336	33,248	40,160
195%	Pregnant women/newborn children	23,673	32,097	40,521	48,945
222%	Individuals needing long-term care	26,951	36,541	46,132	55,722

Note: Does not reflect income disregards and asset tests, including 5% income disregard for Healthy Michigan Plan, children, and pregnant women.

Traditional Medicaid Caseloads

From FY 2000-01 to FY 2010-11, Medicaid caseloads increased by over 70%. Since the peak, caseloads have declined by 11%. Medicaid caseloads track more closely to the state's poverty rate than the state's unemployment rate.



Medicaid Services

- Federal law and regulations have established both mandatory and optional medical services that are covered by the program
- Mandatory Medicaid services include:
 - Inpatient and outpatient hospital services
 - Physician's services
 - Nursing facility services
 - Laboratory and x-ray services
 - Emergency services
 - Pregnancy-related services
- Optional Medicaid services covered under Michigan's Medicaid program include:
 - Behavioral health (mental health and substance use disorder)
 - Home- and community-based services (including MI Choice and habilitation support waivers)
 - Pharmaceutical services
 - Adult home help services
 - Dental services (including the Healthy Kids Dental program)
 - Hospice services
 - Program of All-Inclusive Care for the Elderly (PACE)

Medicaid Provider Rates

- States have the flexibility to establish Medicaid provider rates up to the various federal upper payment limits for hospital services, nursing facilities, clinic services, and practitioner services
- These federal upper payment limits generally correspond to Medicare reimbursement rates
- Federal regulations also require that provider rates "be sufficient to enlist enough providers so that services under the [Medicaid state] plan are available to beneficiaries at least to the extent that those services are available to the general population"
- Medicaid is considered the payer of last resort, meaning all other financial resources such as commercial insurance, Medicare, workers compensation, or no-fault automobile insurance are utilized prior to Medicaid provider reimbursement

Medicare Savings Programs

- State Medicaid programs are required to participate in Medicare savings programs, which help low-income Medicare eligible individuals pay for Medicare coverage
- There are four Medicare savings programs:
 - For Medicare eligible individuals up to 100% of FPL, the Qualified Medicare Beneficiaries program pays Medicare Part A (inpatient services) premiums, Medicare Part B (outpatient services) premiums, deductibles, and coinsurances
 - For Medicare eligible individuals between 100% and 120% of FPL, the Special Low Income Medicare Beneficiaries program pays Part B premiums
 - For Medicare eligible individuals between 120% and 135% of FPL, the Qualifying Individuals program pays Part B premiums
 - For Medicare eligible individuals up to 200% of FPL, the Qualified Disabled Working Individual program pays Part A premiums
- Michigan recently implemented a new program for individuals receiving full Medicare and Medicaid coverage (known as "dual eligibles") called MI Health Link
 - Partnership between the state, the federal government, and managed care health plans to provide a single, integrated health plan for all health services
 - Currently available in Southwest Michigan, the Upper Peninsula, Macomb County, and Wayne County
 - Enrollment is voluntary

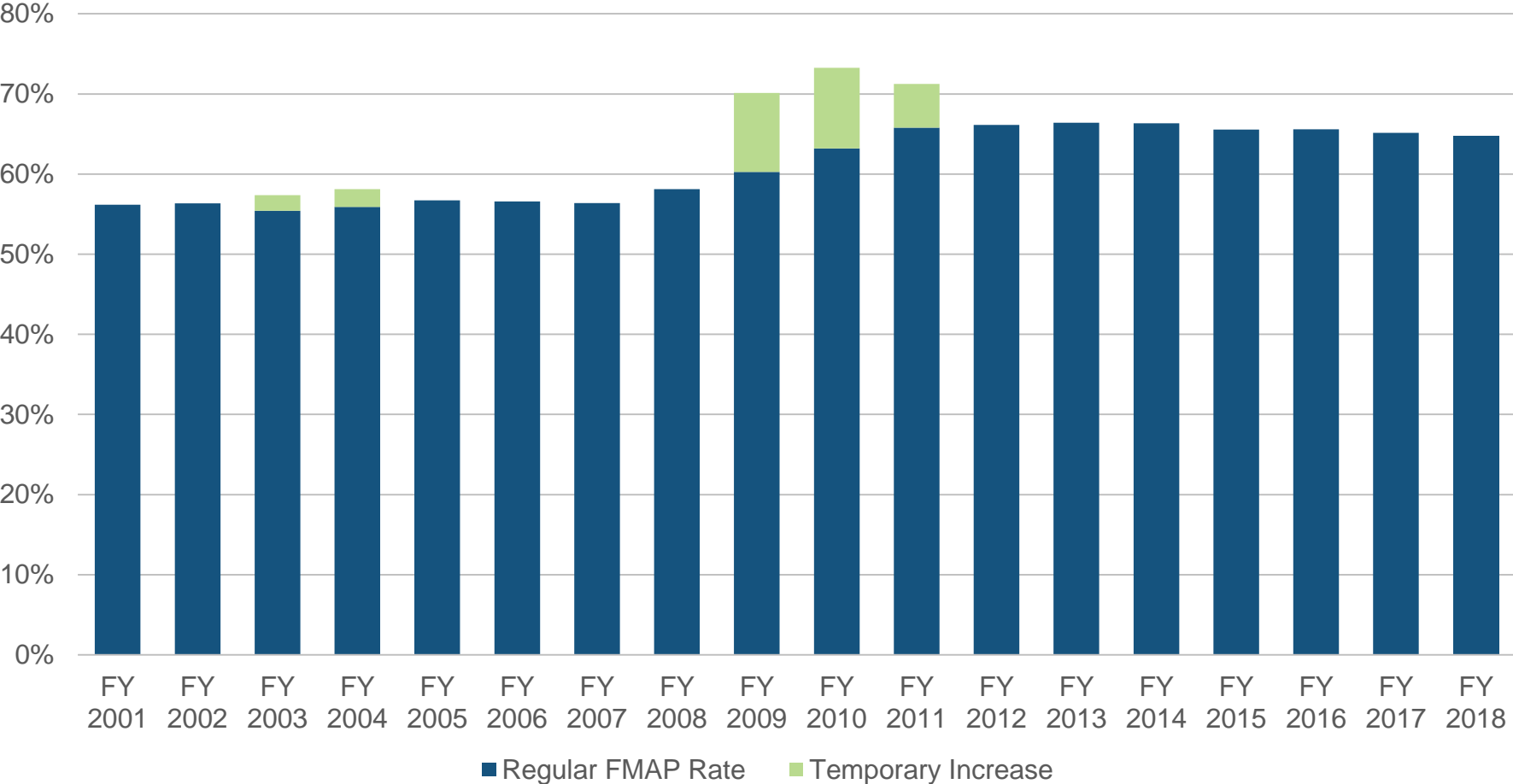
Traditional Medicaid Financing

Federal Medicaid Match Rate

- Traditional Medicaid expenditures are jointly financed by the federal and state governments
- For most expenditures the portion financed by the federal government is determined utilizing the Federal Medical Assistance Percentage (FMAP)
- This rate is adjusted annually based on a comparison of a given state's average personal income to the average national personal income utilizing a three-year average
- For FY 2017-18, Michigan's FMAP rate is 64.78%: the federal government finances 64.78% of Medicaid expenditures, and the state finances the remaining 35.22%. In other words, for each \$1.00 Michigan spends on the Medicaid program, the federal government provides \$1.84

Federal Medicaid Match Rate

The federal Medicaid match (FMAP) rate shifted in the state's favor during the economic downturn as Michigan's economic growth lagged the nation's, reducing state match requirements, but has now begun gradually declining.



Note: Increases for FY 2009 to FY 2011 were due to Federal American Recovery and Reinvestment Act of 2009

Healthy Michigan Plan

Healthy Michigan Plan

- The federal Affordable Care Act, enacted in 2010, required states to expand their Medicaid programs to include all individuals with net income up to 133% of FPL
- A subsequent Supreme Court decision made expansion optional for each state; as of August 1, 2017, 31 states and the District of Columbia have adopted expansion
- The Michigan Legislature expanded Medicaid to adults with income up to 133% of FPL via Public Act 107 of 2013 (House Bill 4714), which created the Healthy Michigan Plan
- The target population for the expansion is adults (ages 19-64), as children and pregnant women with incomes of 133% or lower were already eligible for Medicaid

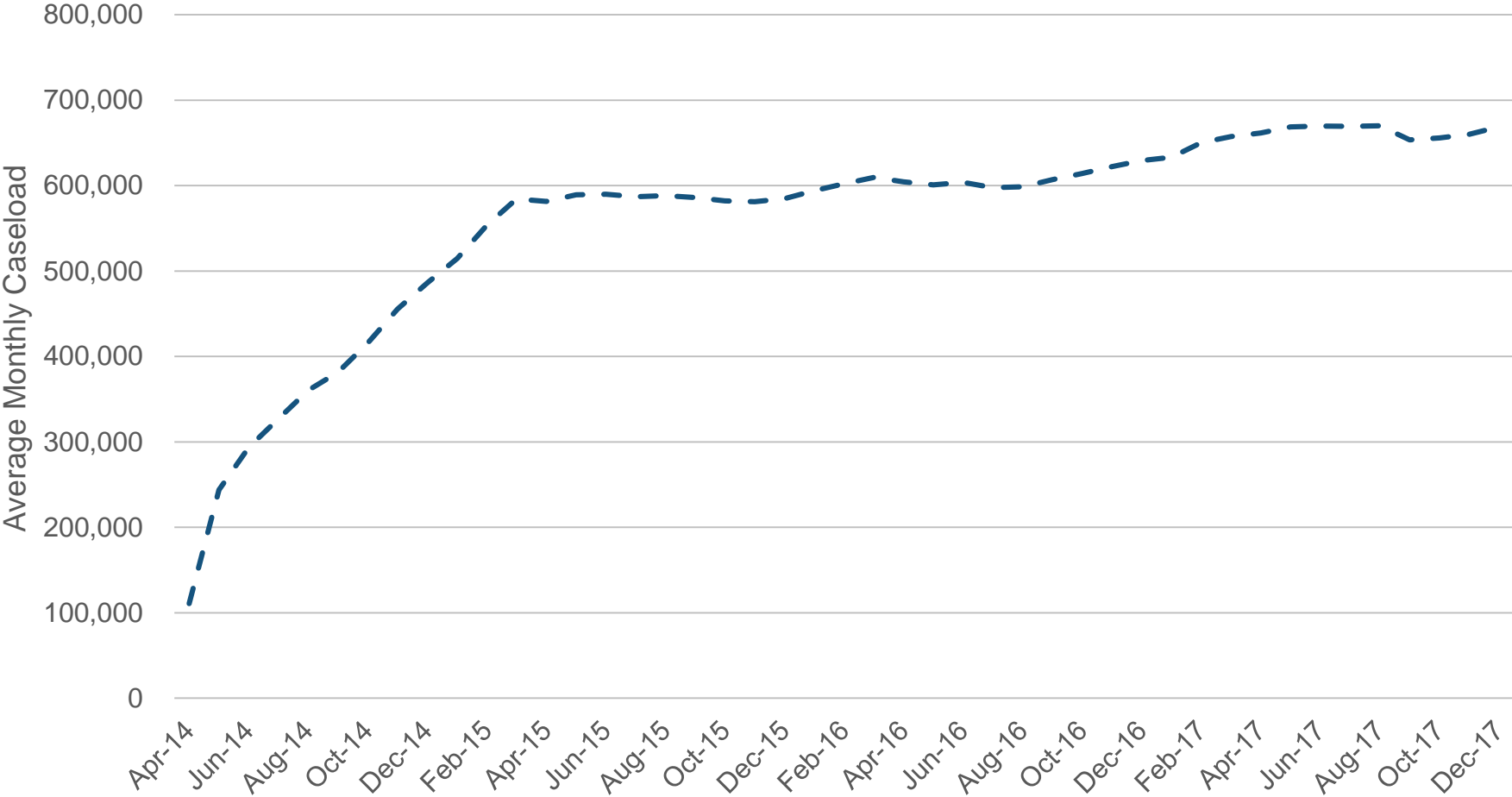
Healthy Michigan Plan Waivers

Public Act 107 required two federal waivers to make a number of modifications from the state's traditional Medicaid program

- An initial waiver approved in December 2013 included the following modifications:
 - Health savings accounts
 - Co-pays and other cost sharing (up to 5% of income for individual with income of 100% of FPL or higher)
 - Certain incentives for healthy behavior
- A second waiver was approved in December 2015 to meet statutory requirements:
 - Individuals enrolled in the program for more than 48 months with income of 100% of the federal poverty level or higher to either:
 - Shift to a health insurance plan purchased on the health insurance exchange created under the Affordable Care Act (utilizing federal subsidies for purchasing health insurance rather than Medicaid funding) or
 - Remain on the Healthy Michigan Plan with higher cost sharing requirements of up to 7% of income
 - Approximately 125,000 of the 670,000 Healthy Michigan Plan beneficiaries have income greater than 100% FPL and are therefore potentially subject to this requirement

Healthy Michigan Plan Caseloads

Healthy Michigan Plan caseloads grew very quickly, reaching over 240,000 individuals in the first two months and then increasing by an average of over 30,000 individuals from May 2014 to March 2015. Cases had plateaued at 600,000 individuals through September 2016. During FY 2016-17 monthly caseloads increased by an average of 7,000 individuals.



Healthy Michigan Plan Financing

Healthy Michigan Plan Financing

- Initially, federal funds supported 100% of costs associated with the Healthy Michigan Plan. That federal match rate will phase down to 90% over the next five years:
 - 95% for 2017 (calendar year)
 - 94% for 2018
 - 93% for 2019
 - 90% for 2020 and subsequent years
- Based on current HFA projections, state matching costs for the Healthy Michigan Plan were \$140 million in FY 2016-17 (for three-quarters of a year), growing to roughly \$400 million in FY 2020-21 (when the state match rate will be 10% for a full fiscal year)
- Not all of the state matching costs, however, will require additional GF/GP funds. Provider assessments and special financing contributions will be used to support the special Medicaid reimbursements within the Healthy Michigan Plan; additionally, there is a hospital assessment retainer of \$105 million based on special hospital reimbursements within the Healthy Michigan Plan
- HFA projects net GF/GP match costs of \$2 million in FY 2016-17, growing to about \$200 million in FY 2020-21

Healthy Michigan Plan State Savings

- Implementing the Healthy Michigan Plan has also resulted in state savings, as various health care costs previously funded either partially or wholly through state GF/GP revenue have been shifted to 100% federal funding
- Full year GF/GP appropriation reductions of \$235 million are as follows:
 - \$168 million for non-Medicaid mental health funding (originally \$204 million, with \$36 million subsequently restored)
 - \$47 million for the Adult Benefits Waiver program (including \$12 million in restricted Medicaid Benefits Trust Fund savings that had offset GF/GP)
 - \$19 million for prisoner health care costs in the Department of Corrections budget (originally \$32 million, with \$13 million subsequently restored)
 - \$1 million for smaller health care programs
- Additionally, the state has realized additional revenue from the Health Insurance Claims Assessment (HICA) and the Use Tax on Medicaid managed care organizations as a result of increased health care activities driven by the Healthy Michigan Plan
- Governor's original proposal for Healthy Michigan Plan included the creation of a reserve fund to pay for future state match costs; Public Act 107, ultimately, did not specifically set aside state funds for future Healthy Michigan Plan costs

Healthy Michigan Plan Saving and Cost Estimates

Healthy Michigan Plan: Estimated State Costs/Savings In Millions of \$

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Average monthly beneficiaries	286,300	544,400	597,200	650,000	670,000	670,000	670,000	670,000
State match rate	0.00%	0.00%	0.00%	3.75%	5.75%	6.75%	9.25%	10.00%
State Costs								
State match and admin costs	\$20	\$20	\$20	\$156	\$233	\$275	\$377	\$414
Less restricted revenues	0	0	0	(135)	(151)	(160)	(181)	(189)
Total GF/GP Costs	\$20	\$20	\$20	\$22	\$83	\$116	\$196	\$224
Budget Savings (1)								
Non-Medicaid Mental Health	(\$77)	(\$168)	(\$168)	(\$168)	(\$168)	(\$168)	(\$168)	(\$168)
Adult Benefits Waiver (2)	(12)	(47)	(47)	(47)	(47)	(47)	(47)	(47)
Corrections health care	(10)	(19)	(19)	(19)	(19)	(19)	(19)	(19)
Other health programs	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal: Budget Savings	(\$100)	(\$235)	(\$235)	(\$235)	(\$235)	(\$235)	(\$235)	(\$235)
Savings from Revenue Impacts								
Additional HICA revenue (3)	(\$7)	(\$20)	(\$21)	(\$27)	(\$30)	(\$30)	(\$23)	\$0
Additional Use Tax revenue (4)	(40)	(162)	(171)	(44)	0	0	0	0
Total Savings With Revenue Impacts	(\$147)	(\$417)	(\$427)	(\$306)	(\$265)	(\$265)	(\$258)	(\$235)
Net GF/GP Costs/(Savings)	(\$127)	(\$397)	(\$407)	(\$284)	(\$182)	(\$150)	(\$63)	(\$11)

Notes

- (1) Assumes no inflationary increase in previous state costs shifted to Healthy Michigan Plan.
- (2) Includes \$12 million in Medicaid Benefits Trust Fund revenue appropriated for the program.
- (3) Net of actuarial soundness costs once state match begins. Current HICA sunset is July 1, 2020.
- (4) Use Tax on Medicaid Managed Care Organizations was discontinued effective January 1, 2017.

General Note: Does not reflect local savings or reductions in uncompensated care (which could result in reductions to Disproportionate Share Hospital [DSH] payments under HMP statutory provisions).

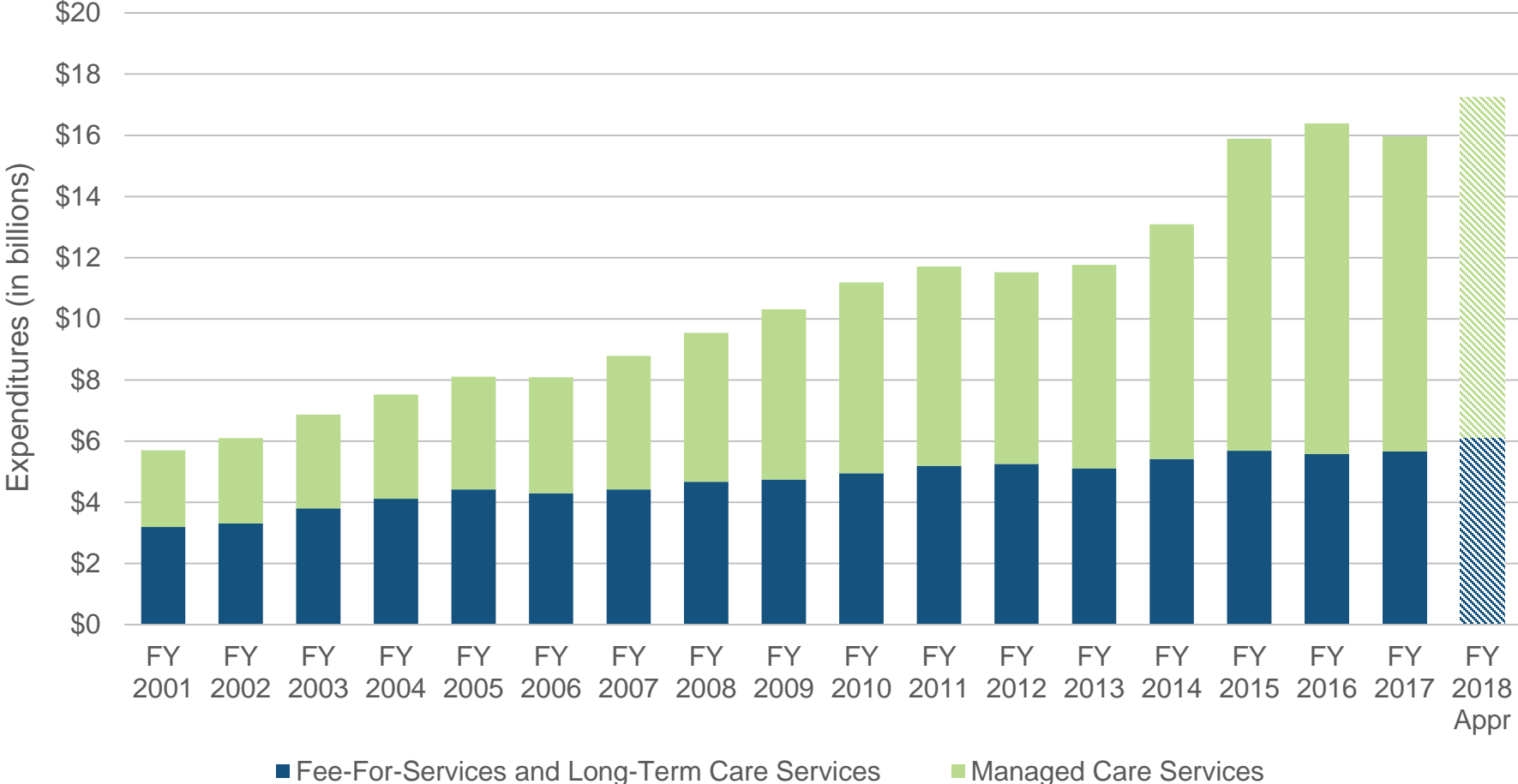
Healthy Michigan Plan Sunset

- Under current statutory provisions, the Healthy Michigan Plan will sunset whenever the net costs of the program exceed the savings, as determined by the Department of Health and Human Services
- Current HFA assumptions and estimates indicate net Healthy Michigan Plan savings through at least FY 2019-20
- Discontinuation of Healthy Michigan Plan will require either restoration of funding for mental health and other health care services or reductions from previous levels of services provided
- DHHS and the State Budget Office are statutorily charged with determining and approving precise costs and savings, respectively, so the HFA estimates presented should be considered preliminary in nature

Total Medicaid Expenditures

Medicaid Expenditures by Service Delivery

Since FY 2000-01, both fee-for-service and managed care services have increased, but managed care services have increased faster as a growing percentage of Medicaid beneficiaries have been enrolled into a managed care health plan. 73% of beneficiaries are currently covered through managed care, representing 65% of expenditures.

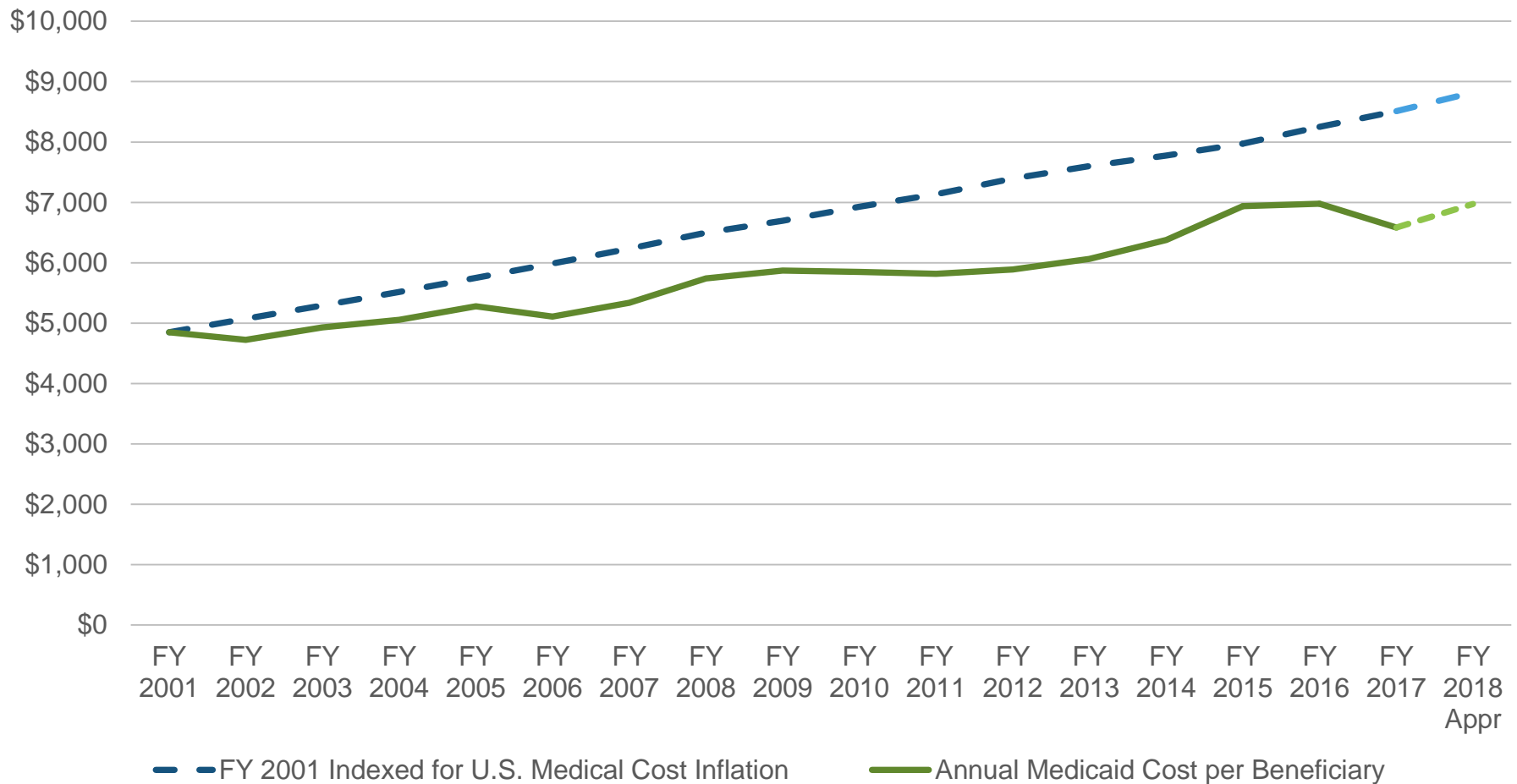


Medicaid Managed Care

- The use of managed care is intended to constrain costs by minimizing utilization of higher-cost services, emphasizing primary and preventative care, and negotiating and incentivizing lower reimbursement rates with providers
- Managed care plans accept the risk of having to pay for high utilizers of health care by accepting a capitated per-member, per-month rate
- The capitated rates must be actuarially sound based on generally accepted actuarial practices and regulatory requirements
- Managed care also creates more predictability for state budgeting
- Managed care enrollment is optional for some groups of Medicaid beneficiaries: migrants, Native Americans, and dual eligibles
- Some beneficiaries are excluded from managed care enrollment: individuals without full Medicaid coverage, individuals residing in a psychiatric hospital or nursing facility, MI Choice and PACE beneficiaries, and individuals with commercial coverage

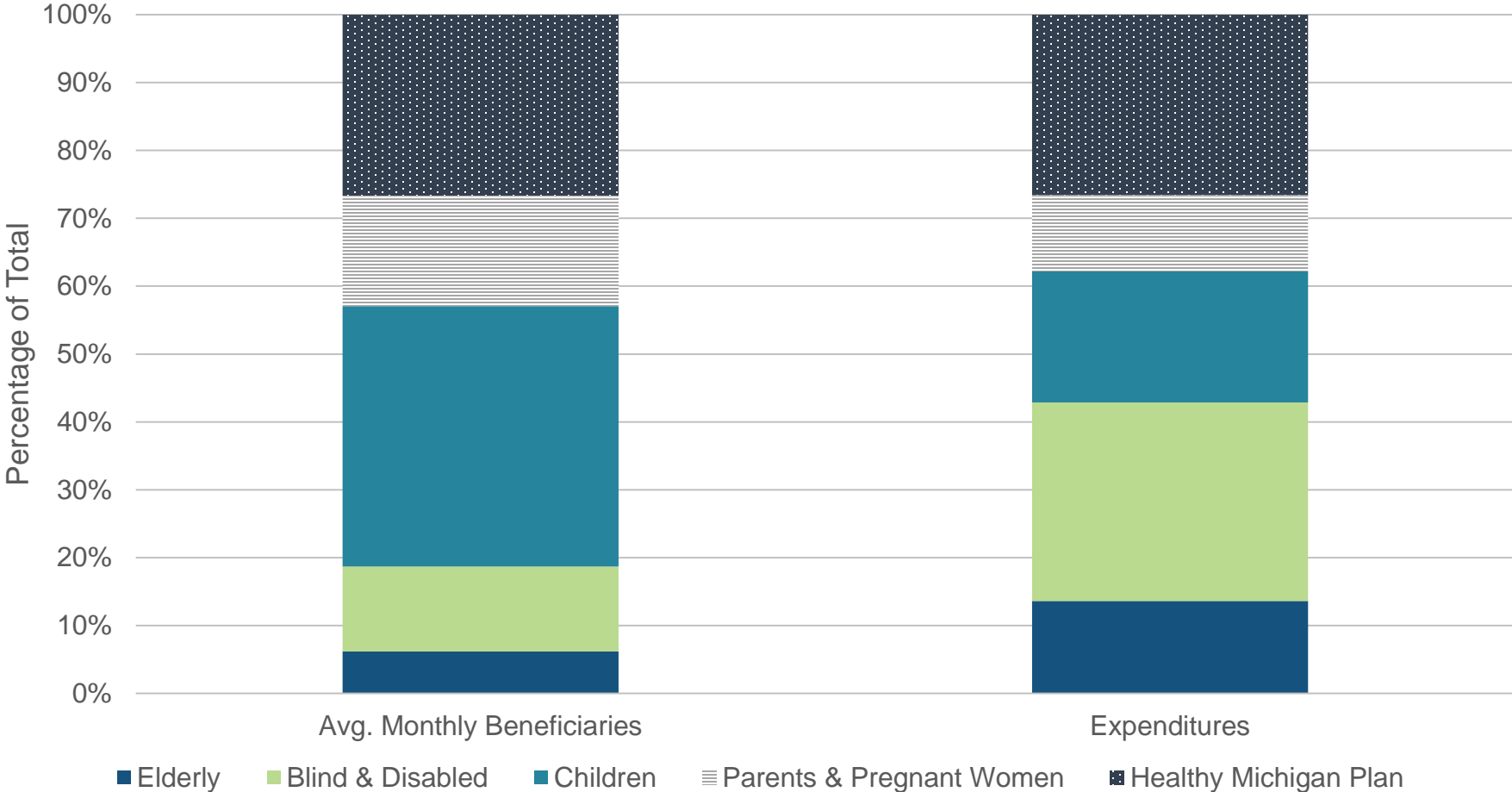
Annual Cost per Medicaid Beneficiary

Caseload increases are not the sole reason for Medicaid expenditure increases. Utilization, inflation, and increases in special payments and provider assessments also affect costs. The average cost per Medicaid beneficiary has increased 44%, from \$4,900 to \$7,000, since FY 2000-01. This increase is below the rate of general medical cost inflation.



Medicaid Beneficiary and Expenditure Comparison

Average cost per beneficiary varies widely among beneficiary groups. The elderly and blind & disabled represent 19% of beneficiaries, but constitute 43% of the expenditures. Conversely, children make up 38% of beneficiaries, but only constitute 19% of the expenditures.



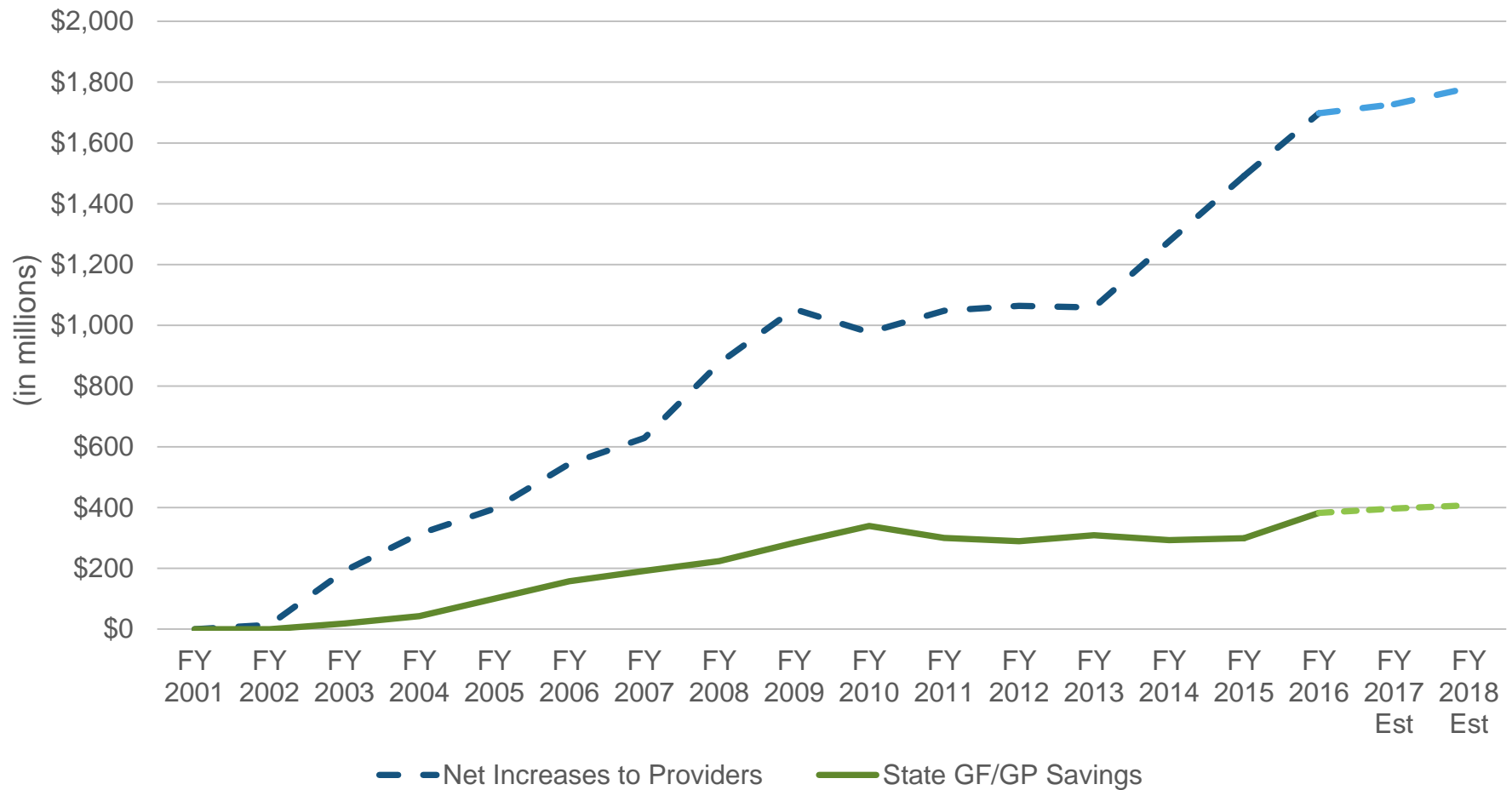
Note: Data are from FY 2016-17.

State Medicaid Match Rate Portion

- For FY 2017-18, \$17.3 billion in Gross Medicaid expenditures requires \$4.7 billion in state match funds
- The largest source of state match funds is General Fund/General Purpose (GF/GP) revenue, at \$2.5 billion
- Over the last 15 years, the state has increasingly relied on state restricted funds to reduce the need for GF/GP funds as state match, with \$2.2 billion in restricted funds appropriated for FY 2017-18
- Restricted fund sources include:
 - Provider assessments, known as the Quality Assurance Assessment Program (QAAP), levied on hospitals, nursing homes, and ambulance providers: \$1.2 billion
 - Medicaid Benefits Trust Fund (primarily from tobacco taxes): \$315 million
 - Health Insurance Claims Assessment: \$390 million
 - Special financing funds from public and university hospitals: \$150 million
 - Merit Award Trust Fund (tobacco settlement revenue): \$46 million

QAAP Provider Increases and State Savings

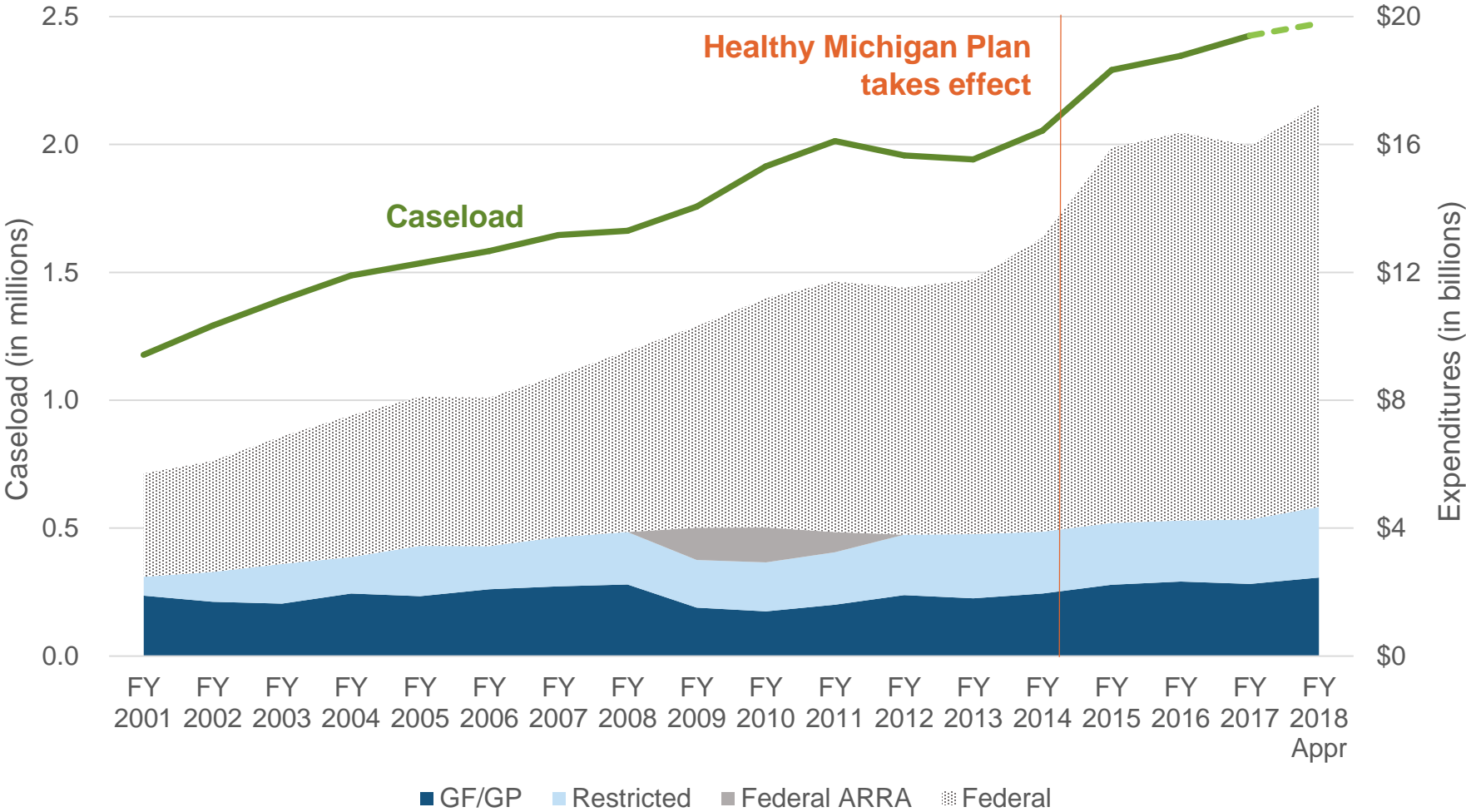
QAAP revenues are used to both increase Medicaid provider rates through supplemental Medicaid payments and offset GF/GP through statutorily established state retainers. Recent increases in both are attributable to the Healthy Michigan Plan.



Medicaid Budget Outlook

Medicaid Expenditures by Fund Source

Since FY 2000-01, the state's total Medicaid caseload has doubled and expenditures have tripled due to economic trends and the expansion under the Healthy Michigan Plan. However, GF/GP spending for Medicaid, has only increased by 30%.



ARRA: Federal American Recovery and Reinvestment Act of 2009

GF/GP Support for Medicaid Expenditures

Three major factors have allowed GF/GP support for Medicaid to be held relatively flat through FY 2017-18:

- 1) The increased use of provider assessments and other state restricted revenue sources as state match. Restricted funds have grown from \$274 million to \$2.2 billion
 - A 2012 GAO report indicates that Michigan is already among the most aggressive states in utilizing provider assessments
- 2) The federal FMAP rate moving in Michigan's favor as the state's economy lagged the national economy in the late 2000's. If Michigan's FMAP was still at the FY 2000-01 rate of 56.18% (instead of 64.78%), the state would need to identify \$1.1 billion in additional state matching funds
 - This trend has reversed due to higher personal income growth in Michigan, resulting in additional GF/GP costs of about **\$40 million** per year
- 3) Initial 100% federal funding for the Healthy Michigan Plan population
 - State match costs for the Healthy Michigan Plan begin on January 1, 2017. This will result in projected GF/GP costs of **\$2 million** for three-quarters of FY 2016-17, increasing to **\$200 million** per year in FY 2020-21
 - Alternately, discontinuing the expanded program and shifting mental health, prisoner health care, and other costs back to state would cost \$235 million per year, plus the GF/GP cost of offsetting lost HICA revenue

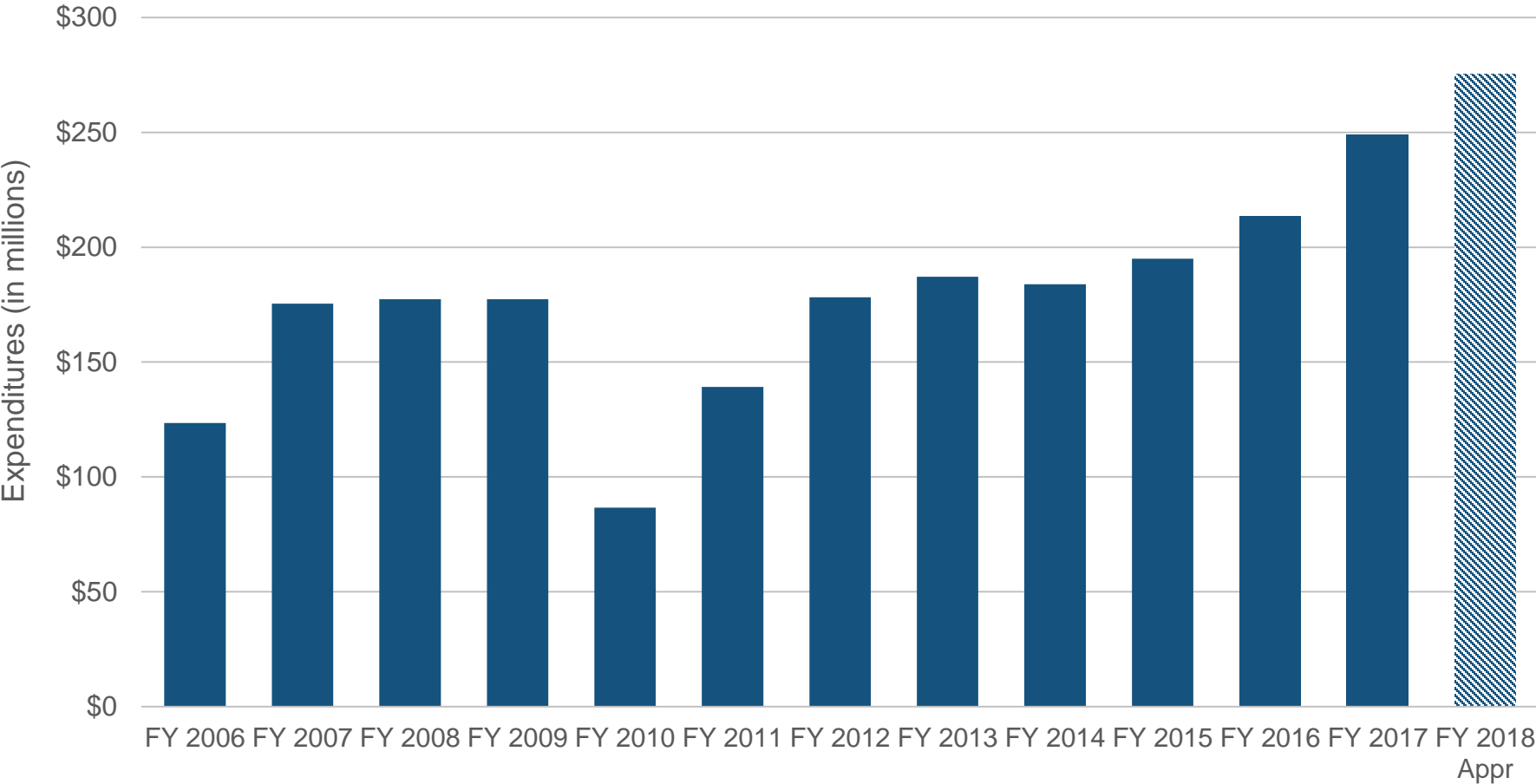
GF/GP Medicaid Spending Pressures

- FY 2017-18 budget assumes traditional Medicaid caseload, utilization, and inflation cost adjustments will increase 2.6%, requiring about **\$120 million** GF/GP
- FY 2017-18 budget assumes Healthy Michigan Plan caseload, utilization, and inflation cost adjustments will increase 5.3%, requiring about **\$30 million** GF/GP
- FY 2017-18 Medicaid managed care organization actuarial soundness payments require roughly **\$40 million** GF/GP for 1% increase in capitated per-member per-month rates

Other Medical Services

Federal Medicare Pharmaceutical Program

The federal Medicare Part D pharmaceutical program began on January 1, 2006, which requires state contributions based on the state costs for pharmaceutical services for persons eligible for both Medicaid and Medicare prior to the creation of Medicare Part D. It is anticipated that state costs will continue to increase due to new specialty drugs.



Children's Special Health Care Services

- Covers special medical care and treatment for children with certain qualifying chronic and/or disabling diagnoses and adults with cystic fibrosis or certain hereditary blood coagulation disorders (e.g. hemophilia)
- Does not cover the cost of providing health care not related to qualifying diagnosis
- Local Health Departments provide enrollment and other case management services for enrollees
- Monthly average of 35,000 children and adults receive CSHCS services
- CSHCS is payer of last resort; around 70% of enrollees are also enrolled in Medicaid, 22% are also enrolled in commercial insurance, and 8% have no other health care coverage
- Total program expenditures of roughly \$750 million financed through GF/GP funding of approximately \$280 million plus federal Medicaid matching funds, Title V - Maternal and Child Health Services Block Grant funds, and parent participation fees.

Behavioral Health Services

Community Mental Health Services

- Mental Health Services are governed through the state's Mental Health Code and annual boilerplate language
- 46 Community Mental Health Services Programs (CMHSPs) have primary responsibility for local service delivery
 - Each county is represented by one of the 46 CMHSPs
- GF/GP non-Medicaid funding is prioritized for services to individuals with the most severe forms of mental illness, serious emotional disturbance, and developmental disability, and to individuals in urgent or emergency situations
 - CMHSPs may also provide other mental health services as resources allow
- CMHSPs cannot deny service based on an individual's inability to pay
- Since the 1970s, the trend has been toward serving more patients in the community and fewer patients in state-operated psychiatric hospitals and institutional settings

Community Mental Health Services Funding

Recent budgetary changes to non-Medicaid mental health include:

FY 2008-09: Executive Order 2009-22 reduced non-Medicaid mental health funding \$10 million

FY 2009-10: Enacted budget reduced non-Medicaid mental health funding an additional \$30 million (for a total full-year reduction of \$40 million)

FY 2013-14: Partial year reduction of \$77 million from shifting costs to Healthy Michigan Plan

FY 2014-15: Additional reduction of \$91 million from shifting costs to Healthy Michigan Plan (for a total full-year reduction of \$168 million)

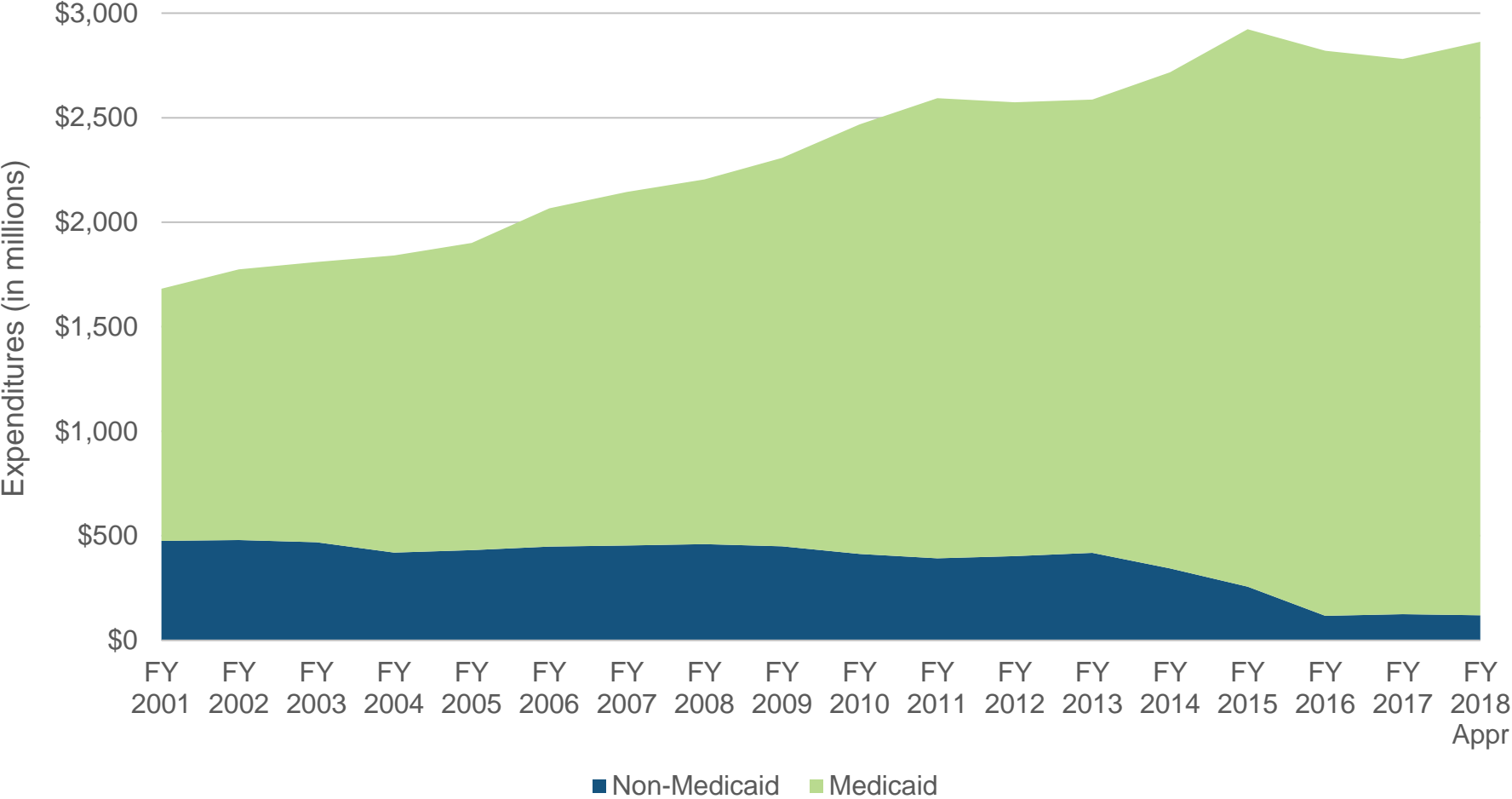
FY 2015-16: DHHS is no longer transferring about \$140 million GF/GP to the CMHSPs for the purchase of state services, as CMHSPs are no longer charged for those services; the GF/GP is instead directly appropriated to support the state psychiatric hospitals

Medicaid Mental Health Services

- Medicaid Mental Health Services are governed through a combination of federal law and regulations, the state's Mental Health Code, annual boilerplate language, and Michigan's Medicaid State Plan
- In general, Medicaid health plans and Medicaid fee-for-service support the cost of mild to moderate mental health services
- In general, Prepaid Inpatient Health Plans (PIHPs) administer specialty mental health services and supports when the need exceeds the benefit provided through Medicaid health plans and Medicaid fee-for-service
- Each CMHSP is a part of one of the 10 PIHPs, which are responsible for distributing Medicaid payments to the CMHSPs for mental health service provision
 - Beginning January 1, 2014, 18 previous PIHPs were re-aligned into the current 10 PIHPs
- PIHPs are managed care organizations and therefore receive a capitated per-member, per-month rate that is required to be actuarially sound based on generally accepted actuarial practices and regulatory requirements
 - These capitated rates just underwent a rebasing process that placed a greater emphasis on morbidity instead of historical spending in order to achieve more statewide uniformity in the capitated rates made to the PIHPs

Mental Health Spending

Since FY 2000-01, total mental health spending has increased 70%. Changes in FY 2013-14 and FY 2014-15 are due to establishment of the Healthy Michigan Plan, which reduced the need for non-Medicaid services. The elimination of the purchase of state services transfer reduced non-Medicaid funding beginning in FY 2015-16.



Behavioral Health Integration

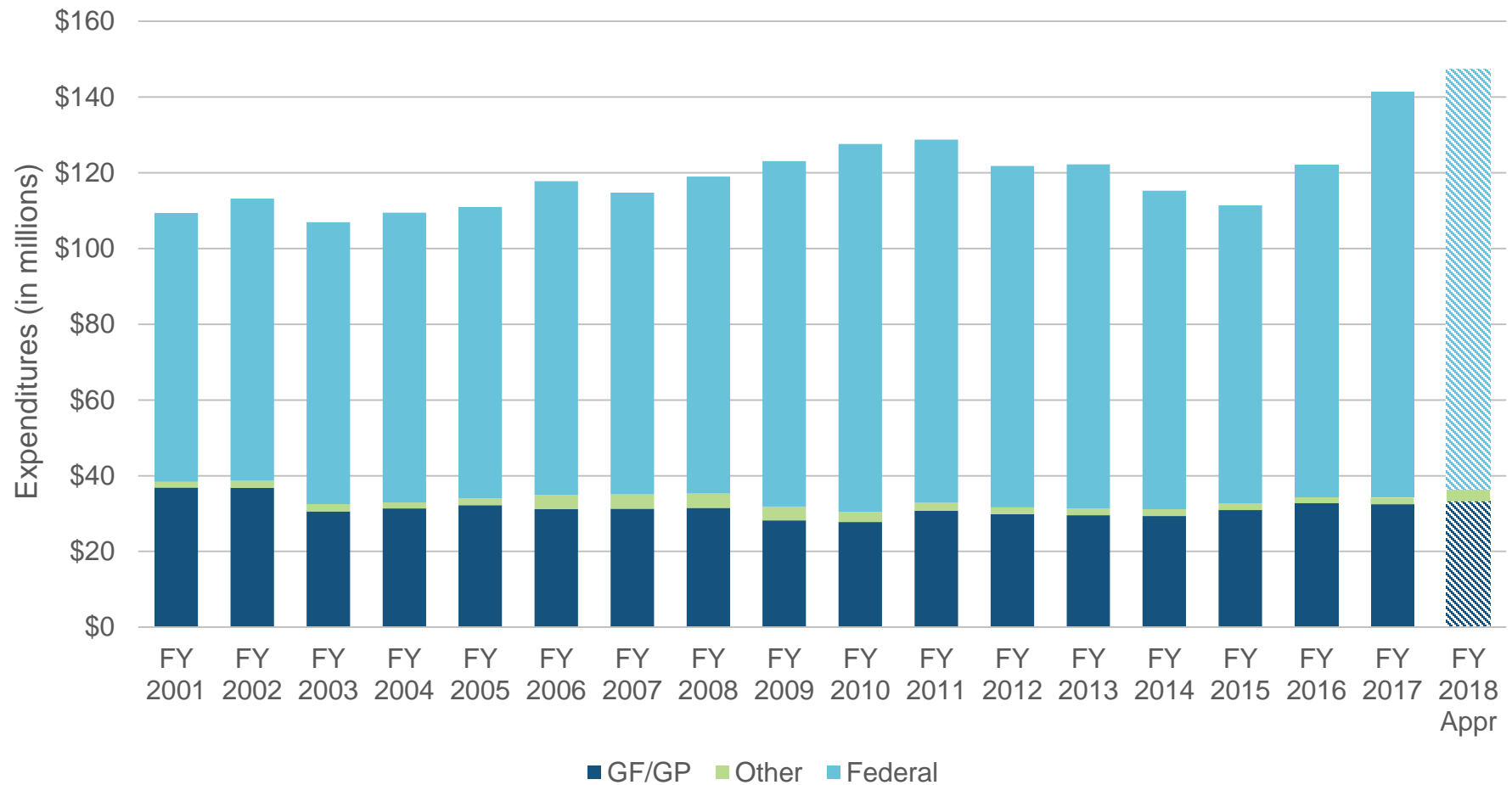
- FY 2016-17 Boilerplate Section 298 required DHHS and a workgroup to make recommendations on both policy and financing to improve coordination between behavioral and physical health services provided through Medicaid
- FY 2017-18 Boilerplate Section 298 requires DHHS to implement financially integrated pilot projects and demonstration models for behavioral health and physical health services with the goal of improving health outcomes and maximizing efficiencies
 - Pilot projects and demonstration models will be evaluated through performance outcome metrics and through an evaluation by a state research university
 - Any realized savings are required to be reinvested in services for individuals that have behavioral health needs in the counties where the savings occurred
- Over FY 2016-17 and FY 2017-18, \$5.9 million Gross (\$2.0 million GF/GP) is provided for an independent project facilitator, evaluation costs, modifications to state contracts, and additional DHHS staff to implement these pilot projects and demonstration models

Substance Use Disorder Services

- Michigan's Mental Health Code requires Department-designated community mental health entity to coordinate the provision of substance use disorder services in its regions and ensure services are available for individuals with substance use disorder
- Effective October 1, 2014, Department-designated PIHP entities are coordinating agencies for purposes of receiving any statutorily required substance use disorder funds
- Substance use disorder services include prevention, education, treatment, and rehabilitation programs
- Majority of funding for substance use disorder services comes from the federal Substance Abuse Prevention and Treatment Block Grant and federal Medicaid reimbursements
- In FY 2016-17, DHHS was awarded a 2-year \$32.8 million federal State Targeted Response to the Opioid Crisis grant

Substance Use Disorder Services Spending

Most of the year-over-year changes in total substance use disorder services expenditures has been driven by the availability of federal funding, including the new State Targeted Response to the Opioid Crisis grant.

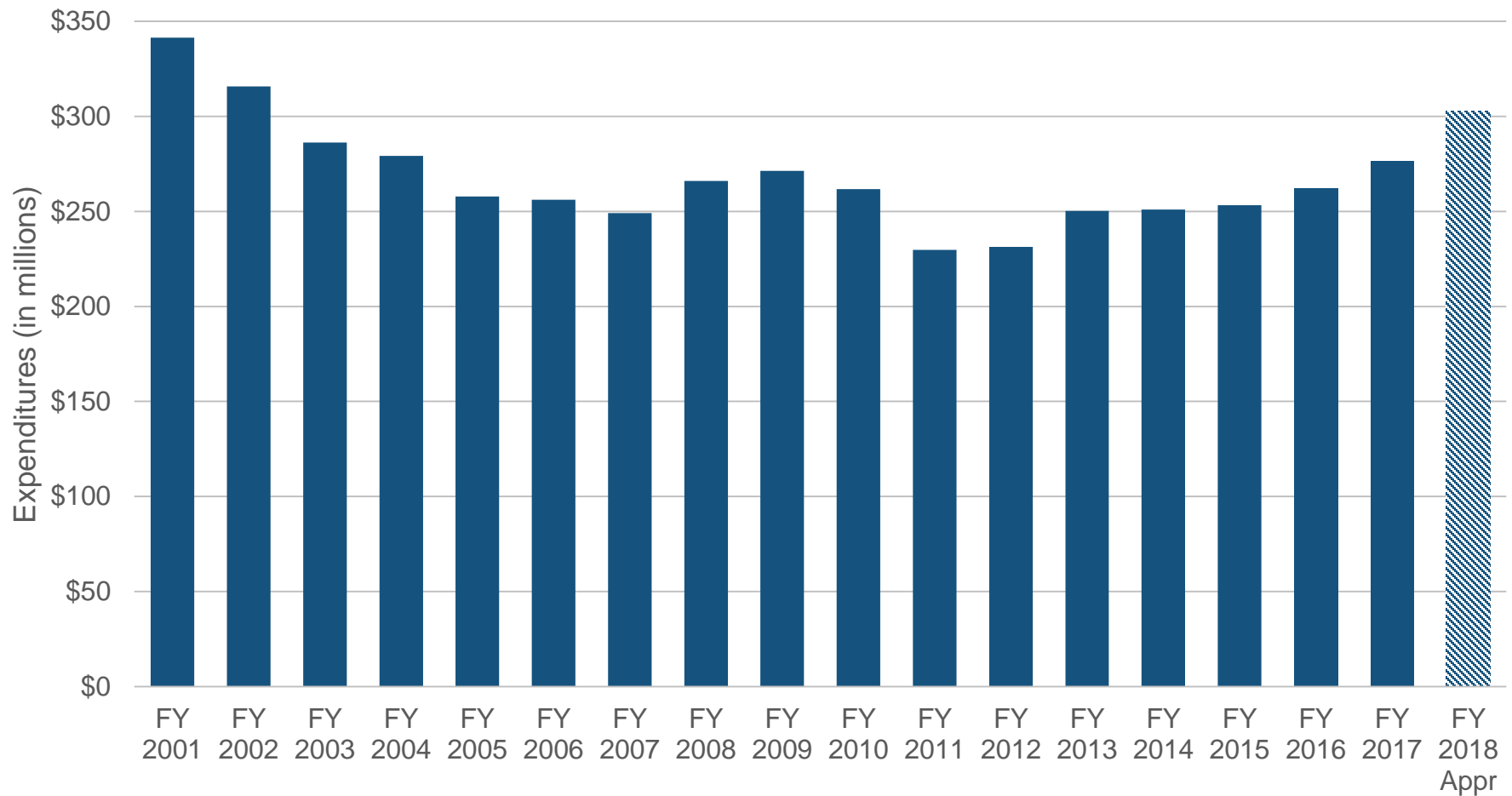


State Mental Health Facilities

- The state has three state-operated psychiatric hospitals for adults
 - Caro Regional Mental Health Center, located in Caro
 - Kalamazoo Psychiatric Hospital, located in Kalamazoo
 - Walther P. Reuther Psychiatric Hospital, located in Westland
- The state has one state-operated psychiatric hospital for children
 - Hawthorn Center, located in Northville
- DHHS is also responsible for the administration of the Forensic Center in Ann Arbor, created for criminal defendants ruled incompetent to stand trial and/or acquitted by reason of insanity
- The state is currently in the process of designing and constructing a new Caro Center at the same site to replace the aging facility, with an estimated completion date of 2021

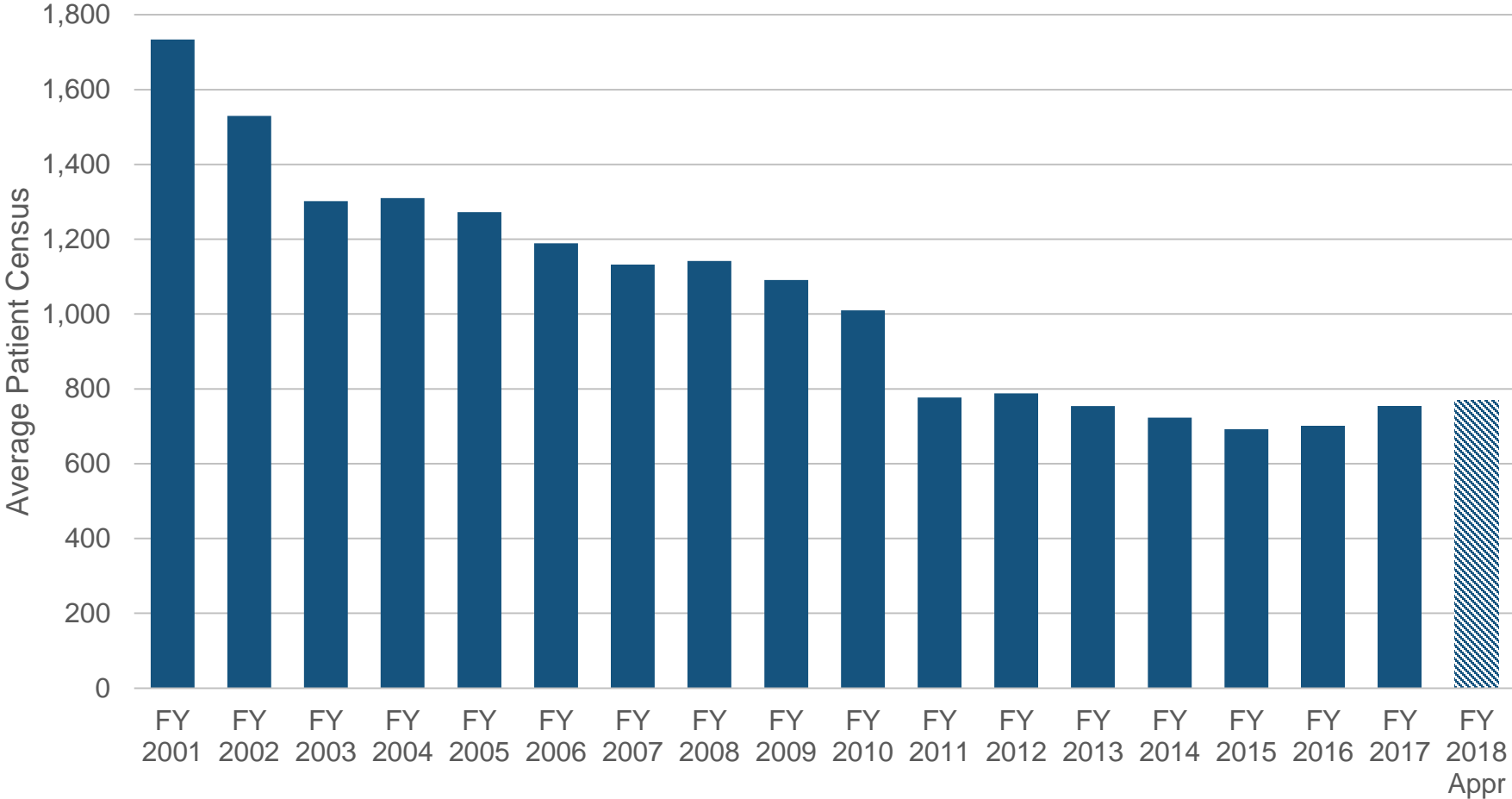
State Mental Health Facility Expenditures and Authorizations

Expenditures for state mental health facilities declined from FY 2000-01 to FY 2006-07 and fluctuated through FY 2012-13 due to facility closures, transfer of responsibilities for Forensic Prisoner Mental Health Services to the Department of Corrections, and reductions in numbers of patients. Expenditures have since begun to increase.



Patients in State Mental Health Facilities

The number of patients in state-operated mental health facilities has fallen since FY 2000-01 due to facility closures, more community-based services, and transfer of responsibilities for Forensic Prisoner Mental Health Services to the Department of Corrections.



For more information about the Health and Human Services budget:

Medicaid/Behavioral Health

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Other HFA Resources

<http://www.house.mi.gov/hfa/HealthandHumanServices.asp>

Medicaid report:

http://www.house.mi.gov/hfa/PDF/HealthandHumanServices/Michigan_Medicaid_Program_Oct2015.pdf