HOUSE FISCAL AGENCY

Budget Briefing: HHS - Medical Services and Behavioral Health

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Briefing Topics

- Funding Sources
- Appropriation Areas
- Major Budget Topics
  - Traditional Medicaid Program
  - Traditional Medicaid Financing
  - Healthy Michigan Plan
  - Healthy Michigan Plan Financing
  - Total Medicaid Expenditures
  - Medicaid Budget Outlook
  - Other Medical Services
  - Behavioral Health Services

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, 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
- The state also funds services for non-Medicaid-eligible individuals through local community mental health programs and Certified Community Behavioral Health Clinics (CCBHC), and operates five psychiatric facilities

Key Budget Terms

Fiscal Year: The state's fiscal year (FY) runs from October to September. FY 2026-27 is October 1, 2026 through September 30, 2027.

Appropriation: Authority to expend funds. An appropriation is not a mandate to spend. The Michigan Constitution prohibits state funds from being expended without an appropriation by the Legislature.

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

Boilerplate: Sections comprising provisional language in a budget bill that direct, limit, or restrict line item expenditures, express legislative intent, and/or require reports for program oversight.

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 GF/GP, state restricted, and federal block grant 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

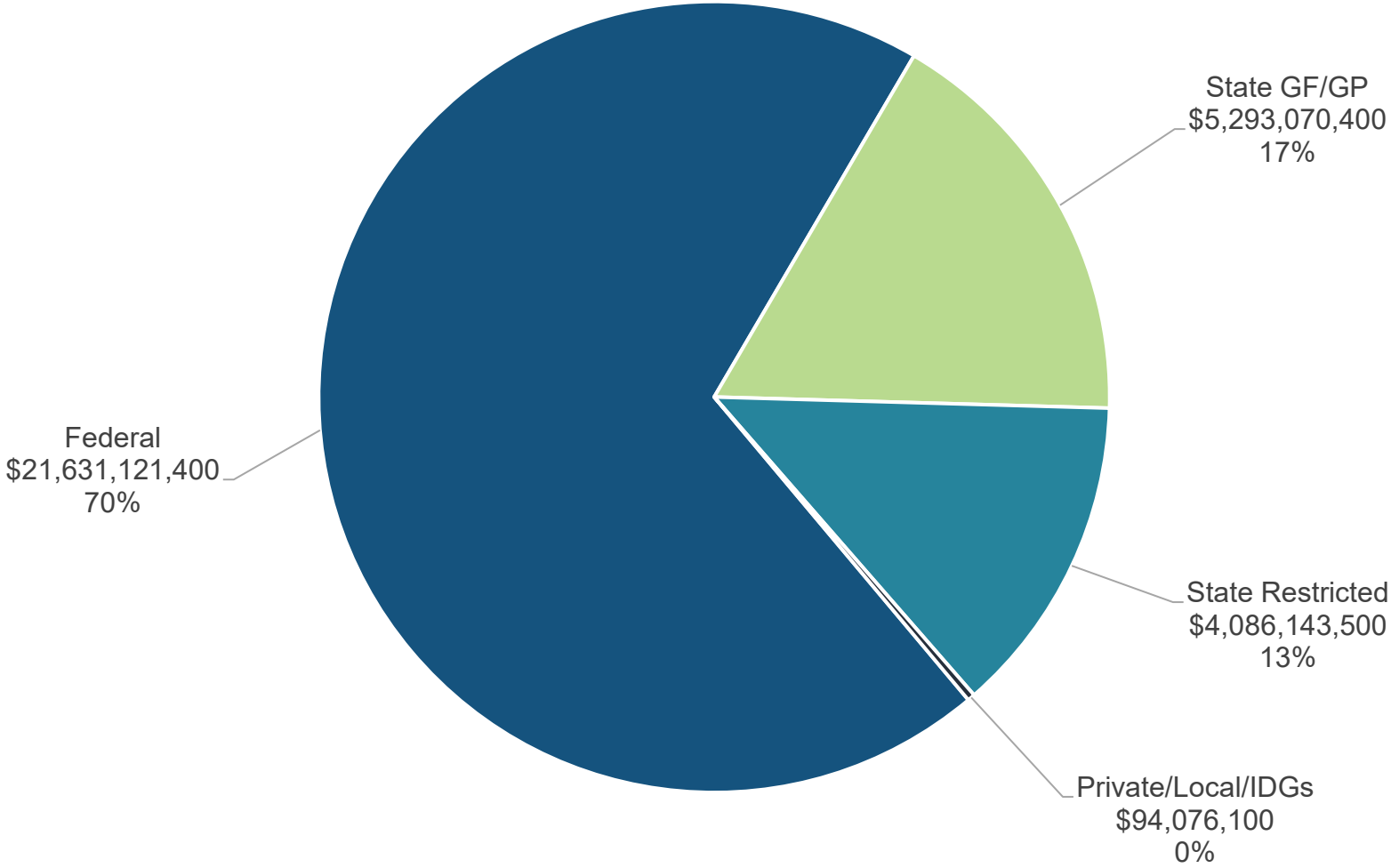
FY 2026-27 Medical Services and Behavioral Health Budget

Fund Source	Funding	Description
Gross Appropriations	$31,104,411,400	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	$31,104,411,400	Gross appropriations excluding IDGs; avoids double counting when adding appropriation amounts across budget areas
Federal Revenue	21,631,121,400	Federal grant or matching revenue; generally dedicated to specific programs or purposes
Local Revenue	68,728,300	Revenue received from local units of government for state services
Private Revenue	25,347,800	Revenue from individuals and private entities, including payments for services, grants, and other contributions
State Restricted Revenue	4,086,143,500	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	$5,293,070,400	Unrestricted revenue from taxes and other sources available to fund basic state programs and other purposes determined by the legislature

Note: These totals include a combined Gross of $9.2 billion in state restricted provider tax revenue and federal Medicaid matching revenue expenditure authorization provided within Sections 1833 and 1834.

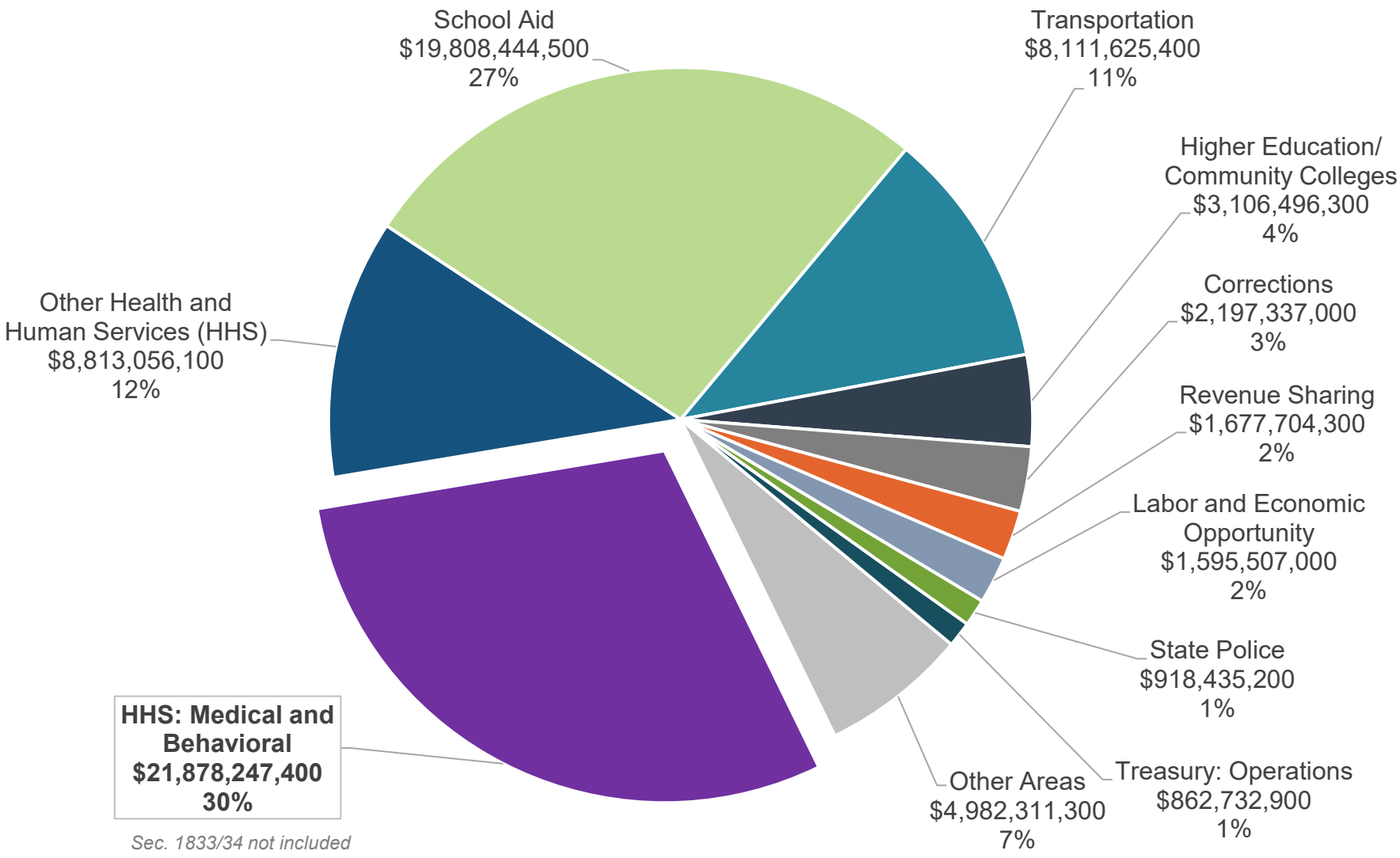
FY 2026-27 Fund Sources

Of the **$31.1 billion** Medical Services and Behavioral Health budget **70%** is funded by federal revenue, almost exclusively Medicaid and Healthy Michigan Plan matching funds.



Medical and Behavioral Health Share of Total State Budget

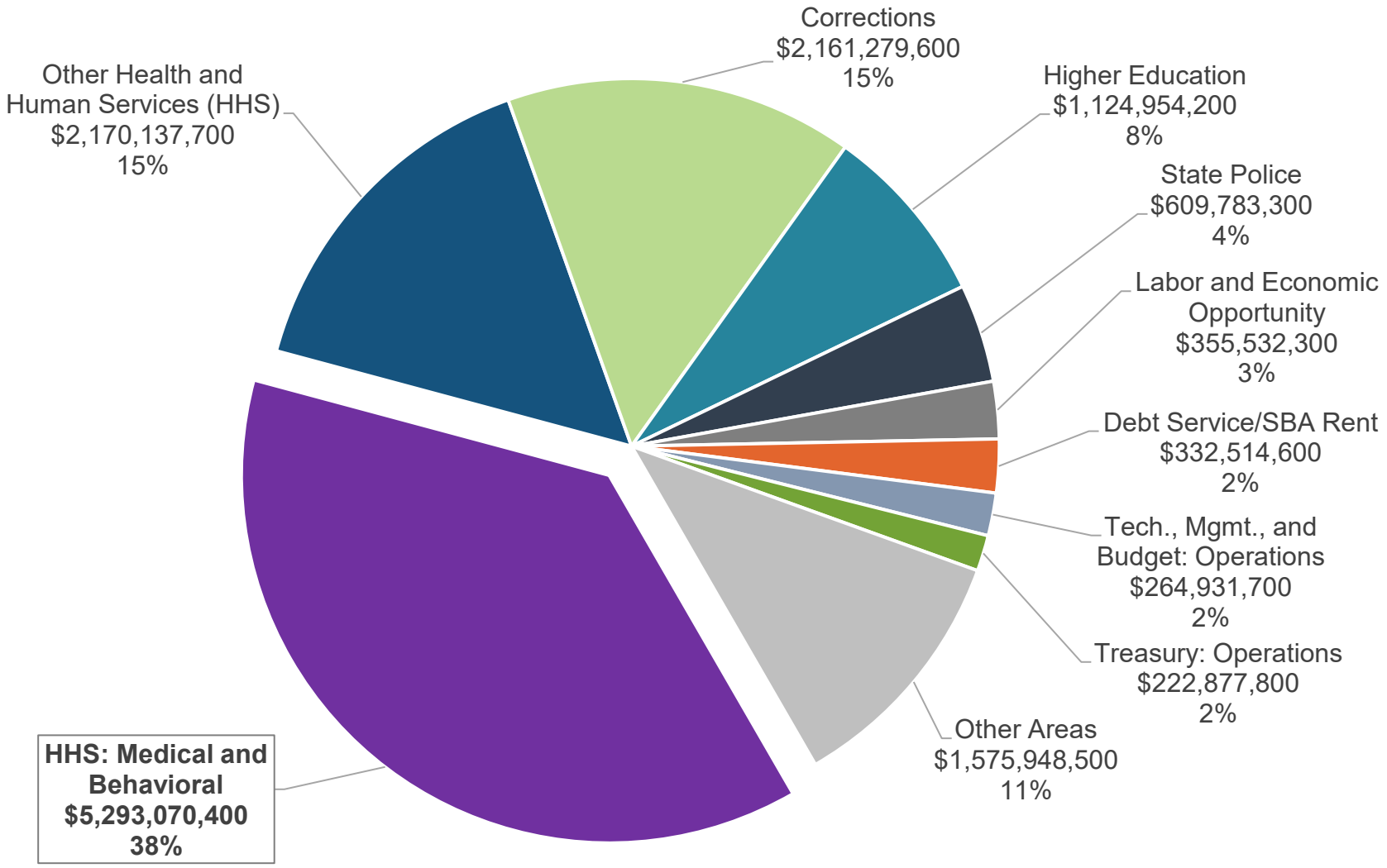
Medical and Behavioral Health Services represent **30%** of the **$74.0 billion** state budget (adjusted gross) for FY 2026-27.



Sec. 1833/34 not included

Medical and Behavioral Health Share of Total GF/GP Budget

Medical and Behavioral Health Services represent **38%** of the state's **$14.1 billion** GF/GP budget for FY 2026-27.



Appropriation Areas

Medical Services and Behavioral Health Appropriation Areas

Administration of the Traditional Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), MIChild, Aging, and Behavioral Health programs

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, Graduate Medical Education (GME) payments, Medicare premium payments, Medicare pharmaceutical "clawback" costs, non-emergency medical transportation, CSHCS, and the MIChild program

Medical services through the Healthy Michigan Plan (HMP)

Special payments made for Special Medicaid Reimbursement to various health providers, School-Based Services, the Dental Clinic Program, Rural Health Transformation Program, and various one-time grants and pilot programs

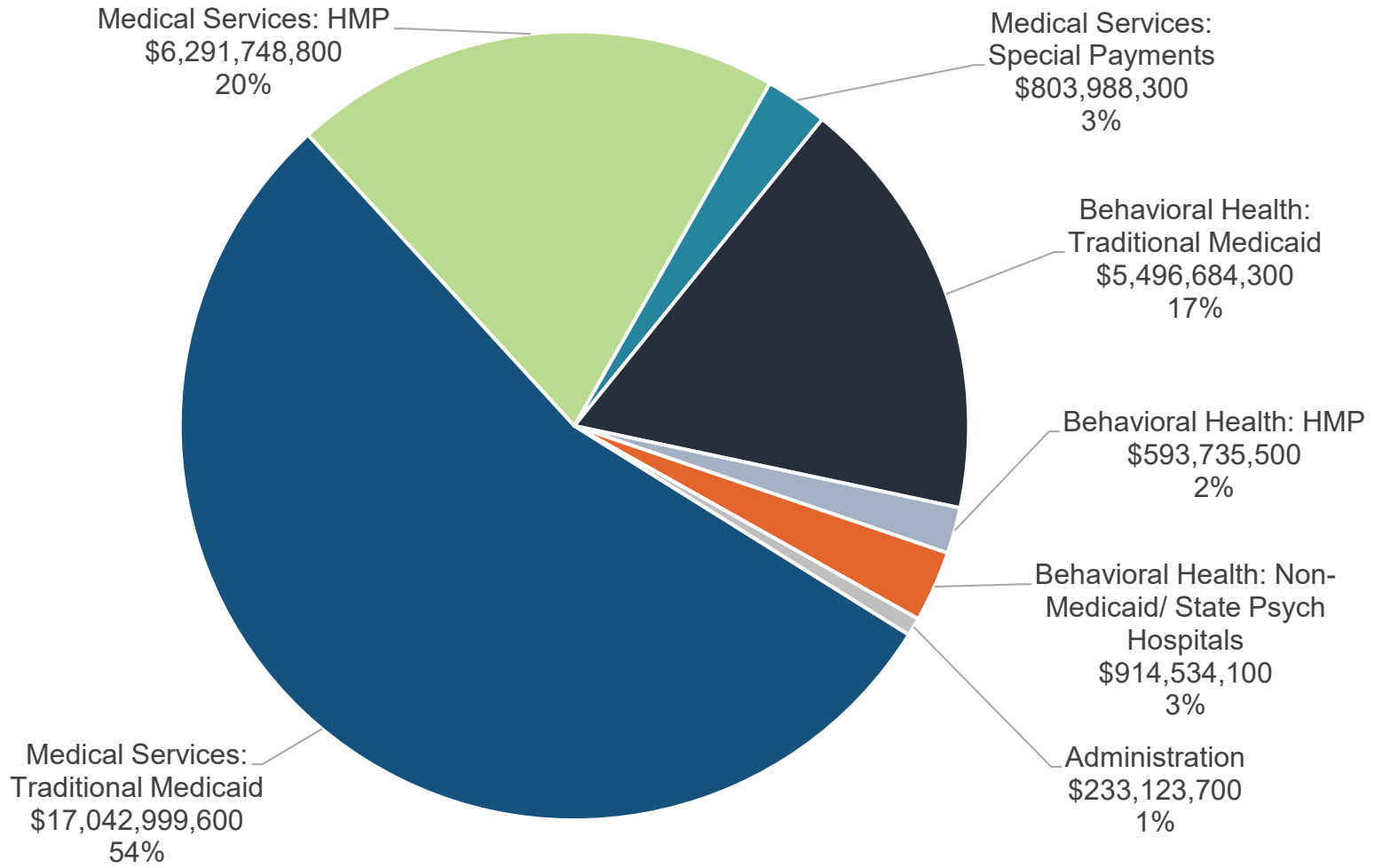
Behavioral health services through the traditional Medicaid program, including mental health services, intellectual/developmental disability services, substance use disorder services, children's waiver programs, and autism services

Behavioral health services through the HMP

Non-Medicaid behavioral health and state psychiatric hospitals

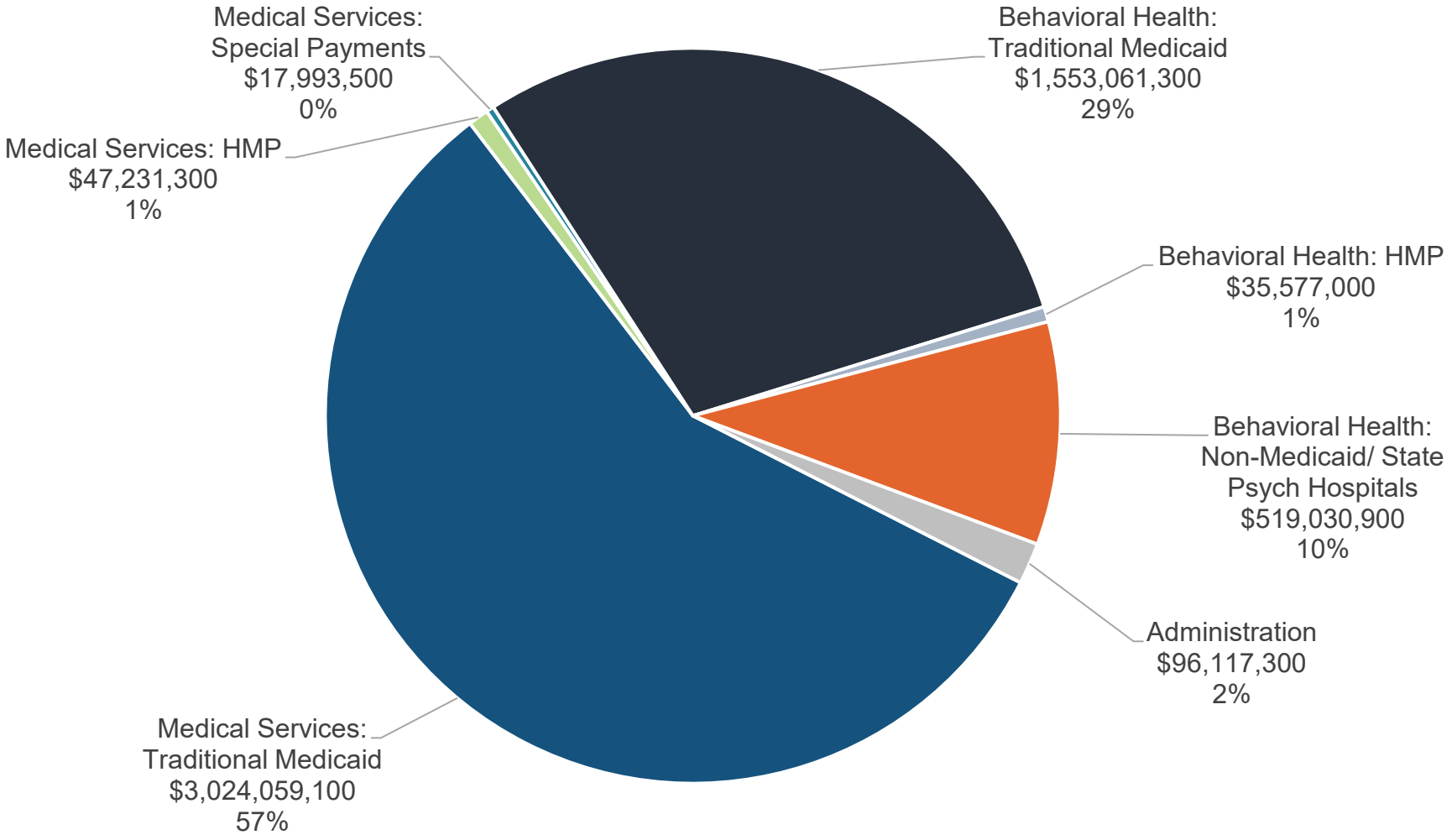
FY 2026-27 Gross Appropriations

Of the **$31.4 billion** Medical Services and Behavioral Health budget **71%** supports the Traditional Medicaid program. Another **22%** supports the Healthy Michigan Plan. Appropriation amount also incudes **$351.0 million** Gross in one-time funding.



FY 2026-27 GF/GP Appropriations

GF/GP funds (totaling **$5.3 billion**) are more heavily concentrated in Behavioral Health Services through the traditional Medicaid program and non-Medicaid programs. Appropriation amount also incudes **$72.2 million** GF/GP in one-time funding.



Major Budget Topics

Traditional Medicaid Program

Medicaid Eligibility

- States have flexibility in establishing 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 225% of FPL (or 300% of SSI)
  - Medically needy individuals with income or resources above regular financial eligibility levels

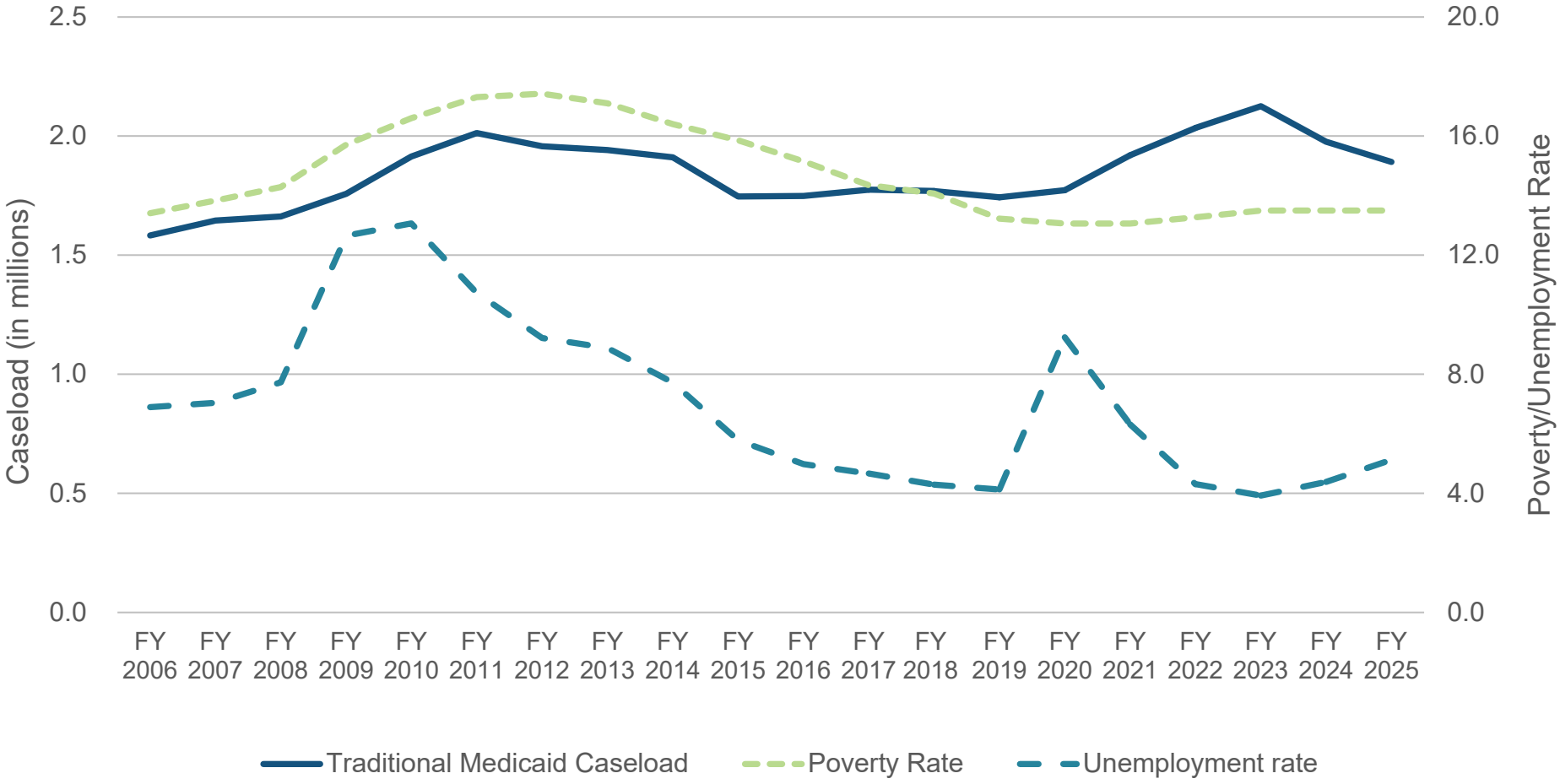
Medicaid Eligibility

2026 Federal Poverty Level Examples					
% of FPL	**Eligibility Group**	**Individual**	**Family of 2**	**Family of 3**	**Family of 4**
100%	Elderly/disabled	$15,060	$20,440	$25,820	$31,200
133%	Healthy Michigan Plan	20,030	27,185	34,341	41,496
160%	Children under 18	24,096	32,704	41,312	49,920
195%	Pregnant women/ newborn children	29,367	39,858	50,349	60,840
225%	Individuals needing long-term care	33,885	45,990	58,095	70,200

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

Traditional Medicaid Caseloads

Following the pandemic, associated federal prohibition on closing Medicaid cases, and completion of the redetermination process, Medicaid caseloads remain **9.0%** above pre-public health emergency levels. Prior to the pandemic, Medicaid caseloads had tracked 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:
  - Specialty behavioral health services (mental health and substance use disorder)
  - Home- and community-based services (including MI Choice and habilitation support waivers)
  - Other practitioner services
  - 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" (42 CFR 447.204)
- 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 implemented a program for individuals receiving full Medicare and Medicaid coverage (known as “dual eligible”) called MI Coordinated Health (MICH)
  - 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

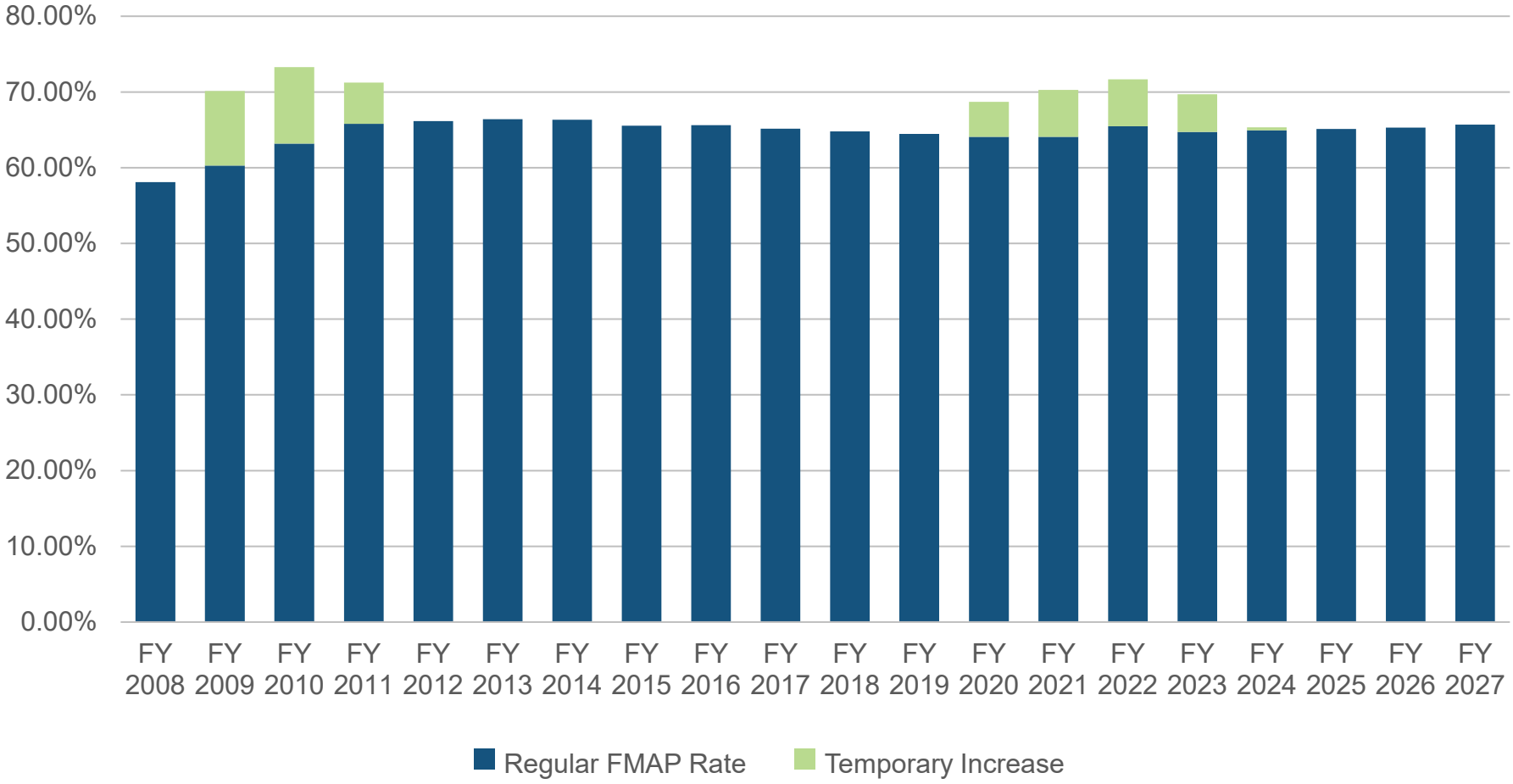
Traditional Medicaid Financing

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 2026-27, Michigan's FMAP rate is 65.70%: the federal government finances 65.70% of Medicaid expenditures, and the state finances the remaining 34.30%. In other words, for each $1.00 Michigan spends on the Medicaid program, the federal government provides $1.92
- Beginning in the second quarter of FY 2019-20, Michigan's FMAP rate was enhanced by 6.2 percentage points as part of the federal government's response to the COVID-19 pandemic via the Families First Coronavirus Response Act of 2020. Recipient states were required to maintain all existing and new Medicaid enrollees for the duration of the federal public health emergency.
- The Consolidated Appropriations Act of 2022 decoupled the expanded FMAP from the public health emergency, and provided for a gradual phase-out schedule beginning April 2023 as states began redetermination of Medicaid enrollees while the federal public health emergency was lifted (the post-pandemic Medicaid redetermination is also colloquially referred to as "Medicaid wind-down").

Federal Medicaid Match Rate

The federal Medicaid match (FMAP) rate shifted in the state's favor during the economic downturn of the late 2000s as Michigan's economic growth lagged the nation's, reducing state match requirements, and has mostly plateaued since then. The enhanced FMAP related to Coronavirus response was phased out by December 2023.



Notes: Increases for FY 2009 to FY 2011 were from Federal American Recovery and Reinvestment Act of 2009
Increase in FY 2020 is from Federal Families First Coronavirus Response Act of 2020

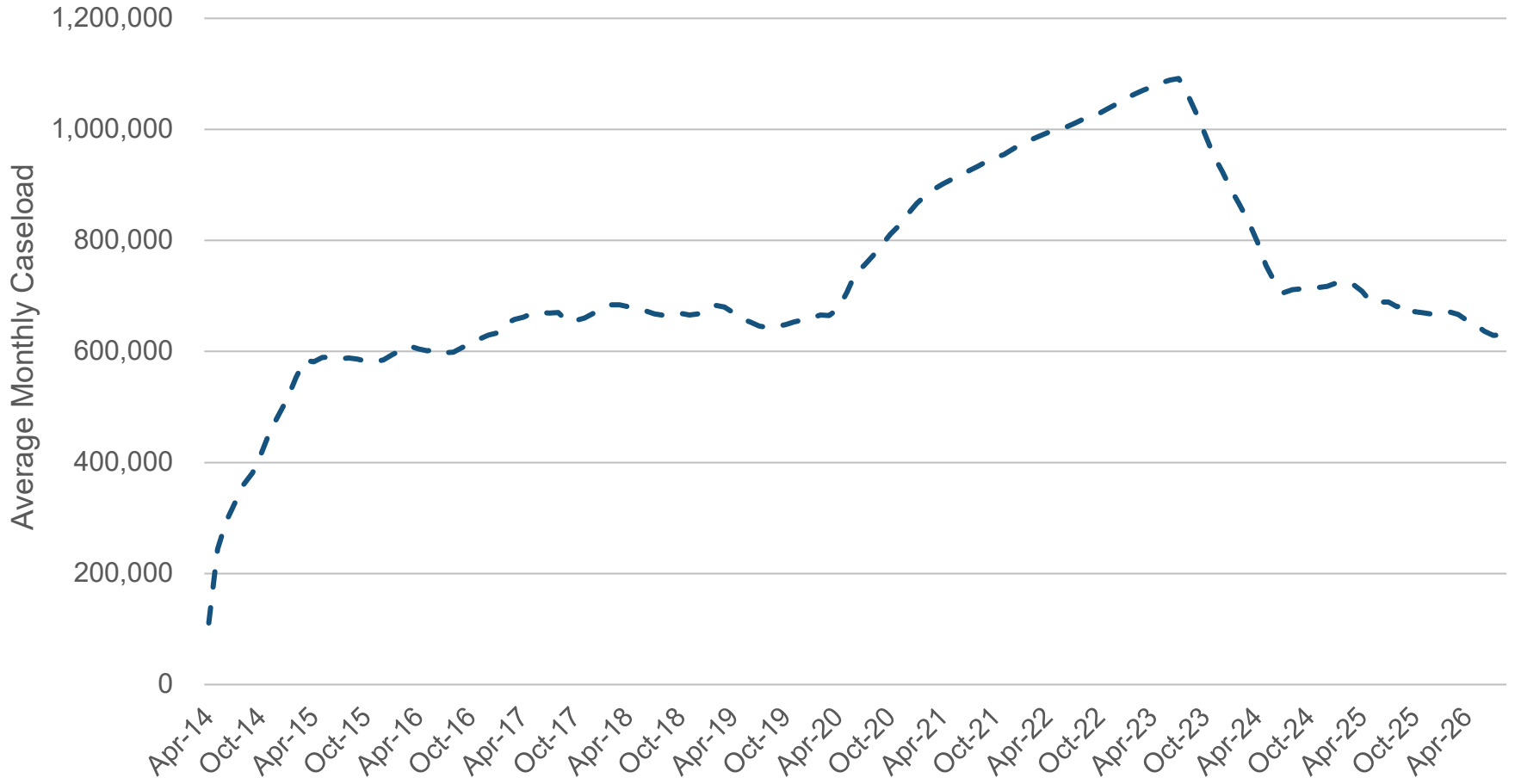
Healthy Michigan Plan

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 November 2024, 40 states and the District of Columbia, have adopted expansion
- 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
- The Michigan Legislature expanded Medicaid to adults with incomes of up to 133% of FPL via Public Act 107 of 2013 (House Bill 4714), which created the Healthy Michigan Plan. The act included sunset provisions, cost-sharing requirements, healthy behavior standards and incentives, Medicaid plan performance incentives, enrollment of beneficiaries in health plans with health savings accounts (or program similar to HSA), and created the Michigan Health Care Cost and Quality Advisory Committee
- The Michigan Legislature revised the Healthy Michigan Plan to include work requirements for able-bodied adults beginning January 1, 2020, via Public Act 208 of 2018 (Senate Bill 897). DHHS received federal approval to implement in December 2018, but a federal judicial ruling determined the work requirements unlawful in March 2020
- In 2023, the Michigan Legislature eliminated the HMP sunset provisions and modified performance incentive requirements via Public Act 98 of 2023 98 (HB 4495)

Healthy Michigan Plan Caseloads

Healthy Michigan Plan caseloads grew very quickly, reaching nearly 600,000 individuals within the first year of implementation. Since the beginning of the pandemic and associated federal prohibition on closing Medicaid cases, Healthy Michigan Plan caseloads increased by **64%**. With the completion of post-public health emergency redeterminations, caseloads have declined by **42%** from the peak and have begun to return to the pre-pandemic trend.



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 phased down to 90% over five years:
  - 95% for 2017 (calendar year)
  - 94% for 2018
  - 93% for 2019
  - 90% for 2020 and subsequent years
- State matching costs for the Healthy Michigan Plan were **$140 million** in FY 2016-17 (for three-quarters of a year), growing to roughly **$679 million** in FY 2025-26
- Not all of the state matching costs, however, 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 $125 million based on special hospital reimbursements within the Healthy Michigan Plan
- Less administrative costs, net GF/GP match costs were **$2 million** in FY 2016-17, growing to about **$118 million** in FY 2025-26

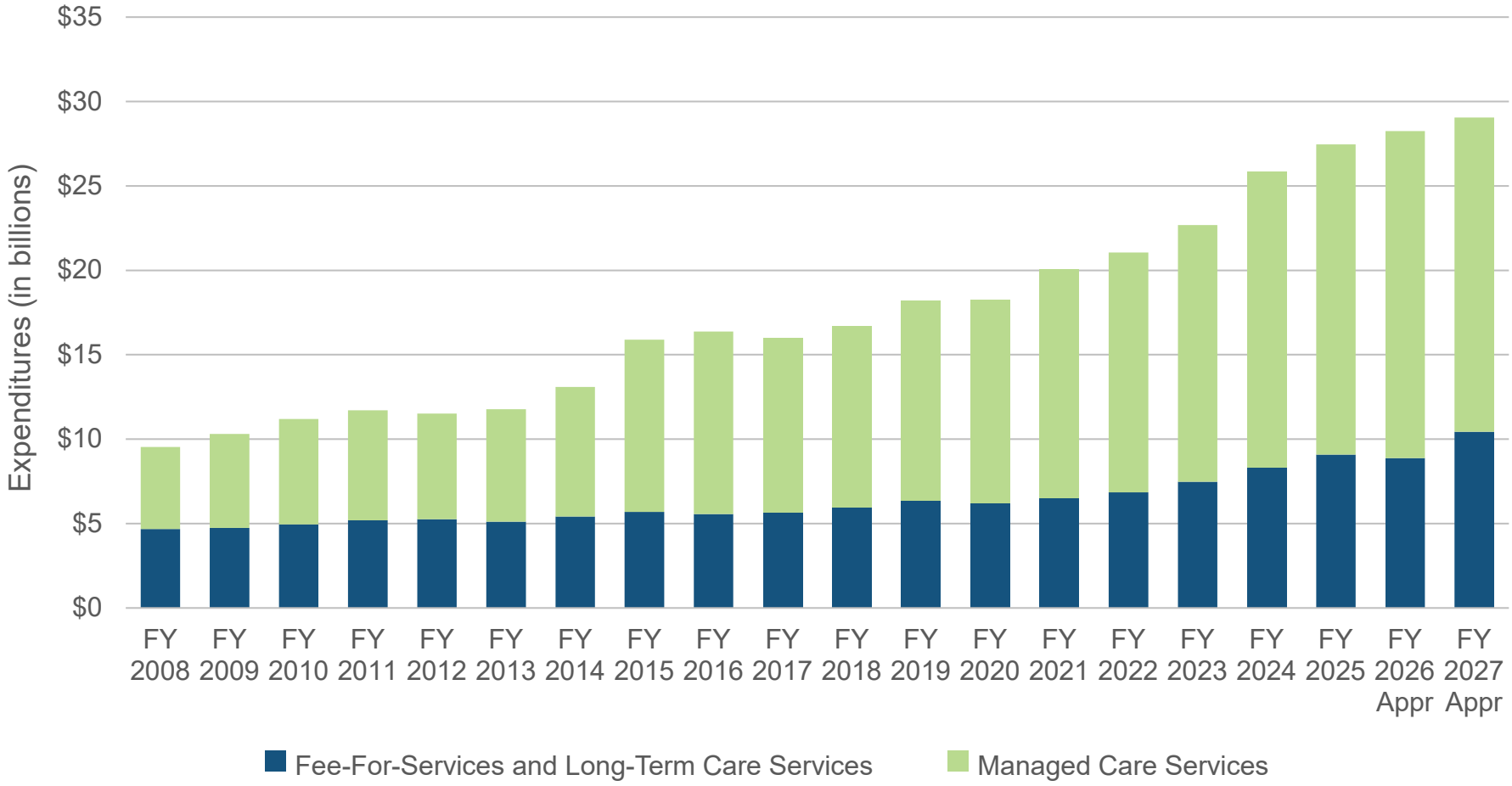
Healthy Michigan Plan State Savings

- 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 **90%** federal funding
- Full year GF/GP appropriation reductions of **$235 million** are as follows:
  - $126 million for non-Medicaid mental health funding
  - $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),the Use Tax on Medicaid managed care organizations, and the current Insurance Provider Assessment (IPA) resulting from increased health care activities driven by the Healthy Michigan Plan

Total Medicaid Expenditures

Medicaid Expenditures by Service Delivery

Since FY 2007-08, 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. **68%** of beneficiaries are currently covered through managed care, representing **64%** of expenditures.

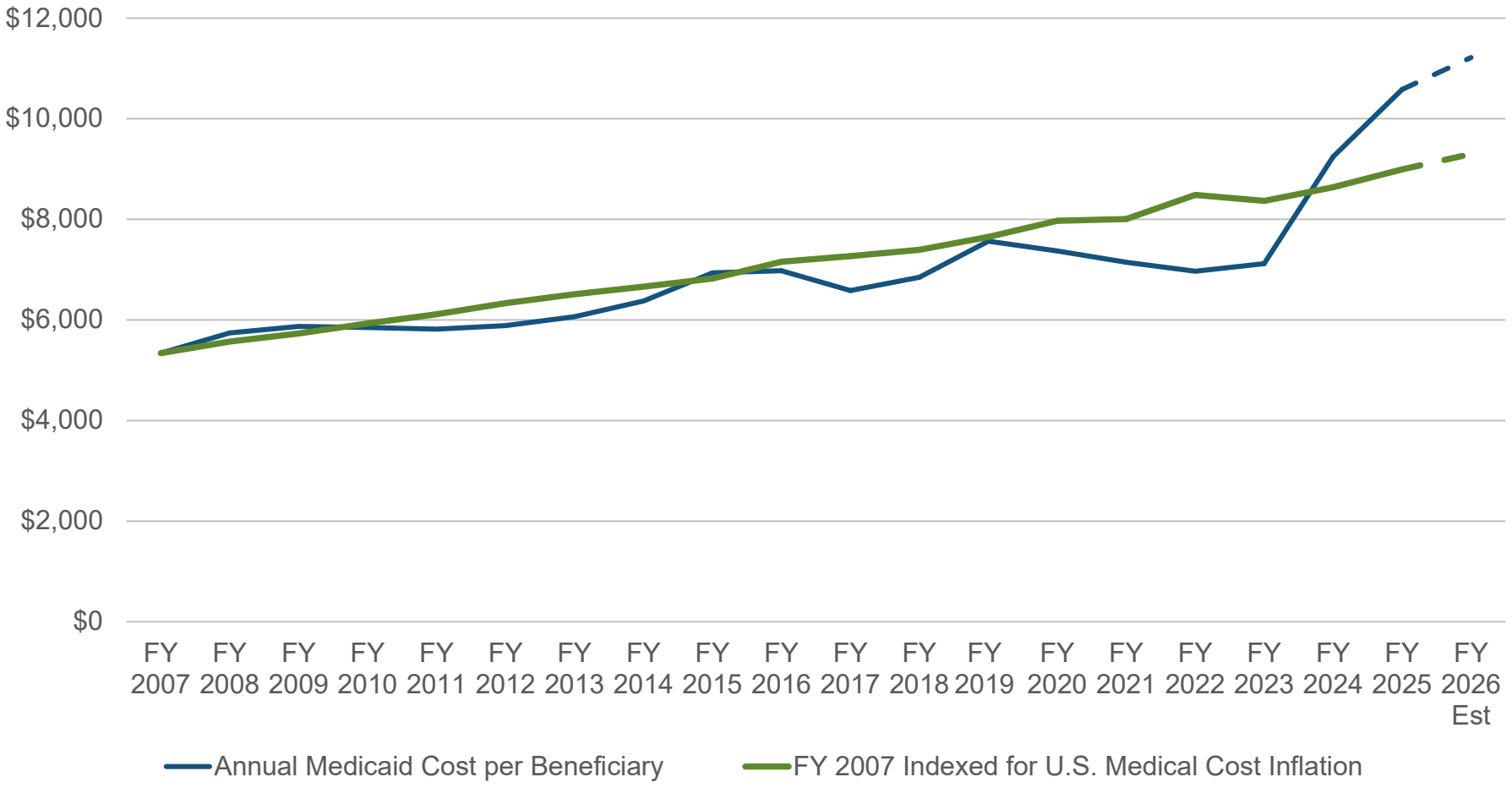


Medicaid Managed Care

- 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 Medicare/Medicaid 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

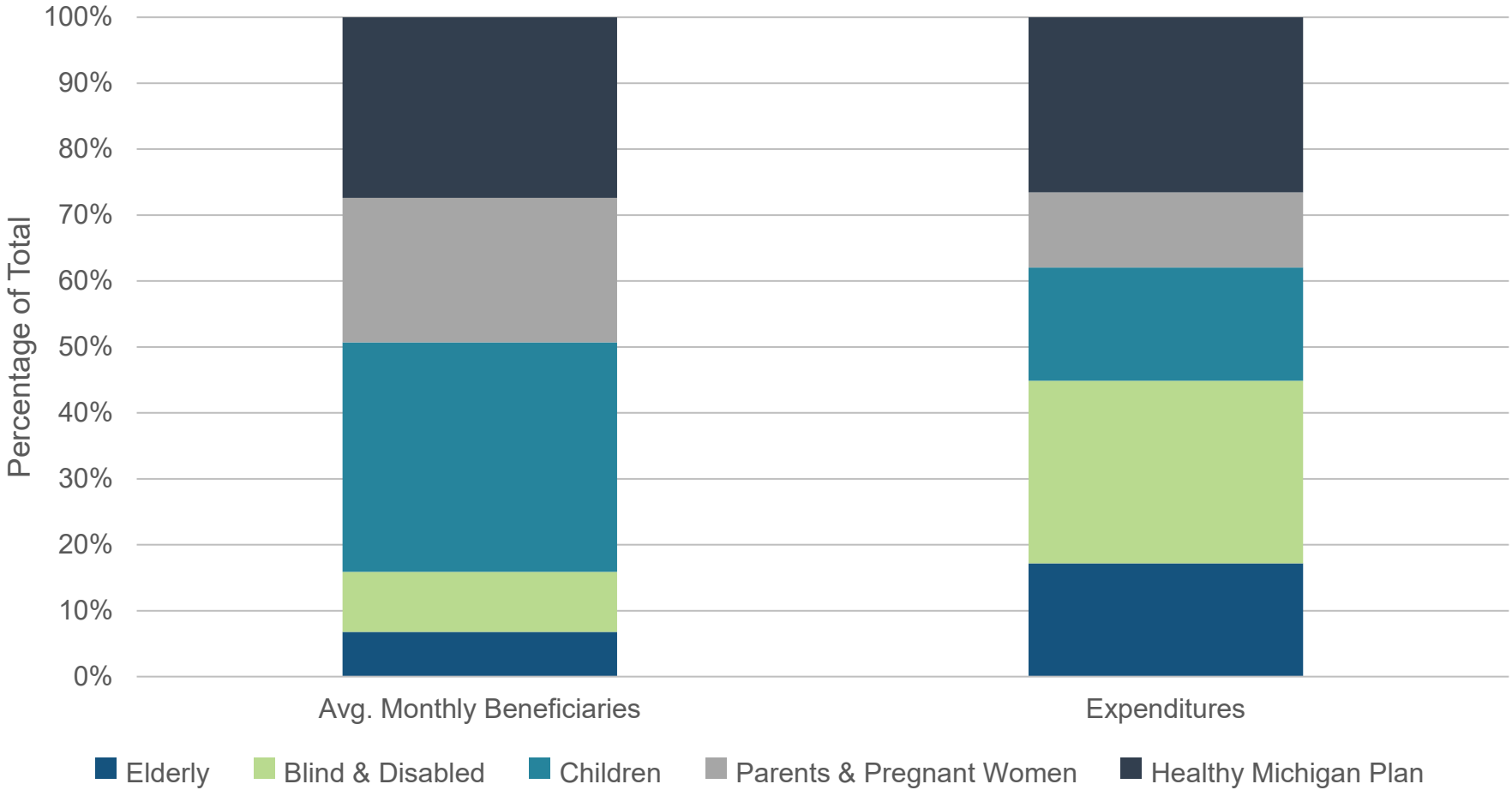
Annual Cost per Medicaid Beneficiary

Caseload increases are not the sole reason for Medicaid expenditure increases. Utilization, inflation, and increases in special payments and provider assessments also affect costs. Since FY 2006-07, the average cost per Medicaid beneficiary has increased **98%**, from **$5,300** to **$10,600** in FY 2024-25. This increase had followed the rate of general medical cost inflation, until FY 2023-24.



Medicaid Beneficiary and Expenditure Comparison

Average cost per beneficiary varies widely among beneficiary groups. The elderly and blind & disabled represent **16%** of beneficiaries, while comprising **45%** of the expenditures. Conversely, children make up **35%** of beneficiaries, but constitute only **17%** of the expenditures.



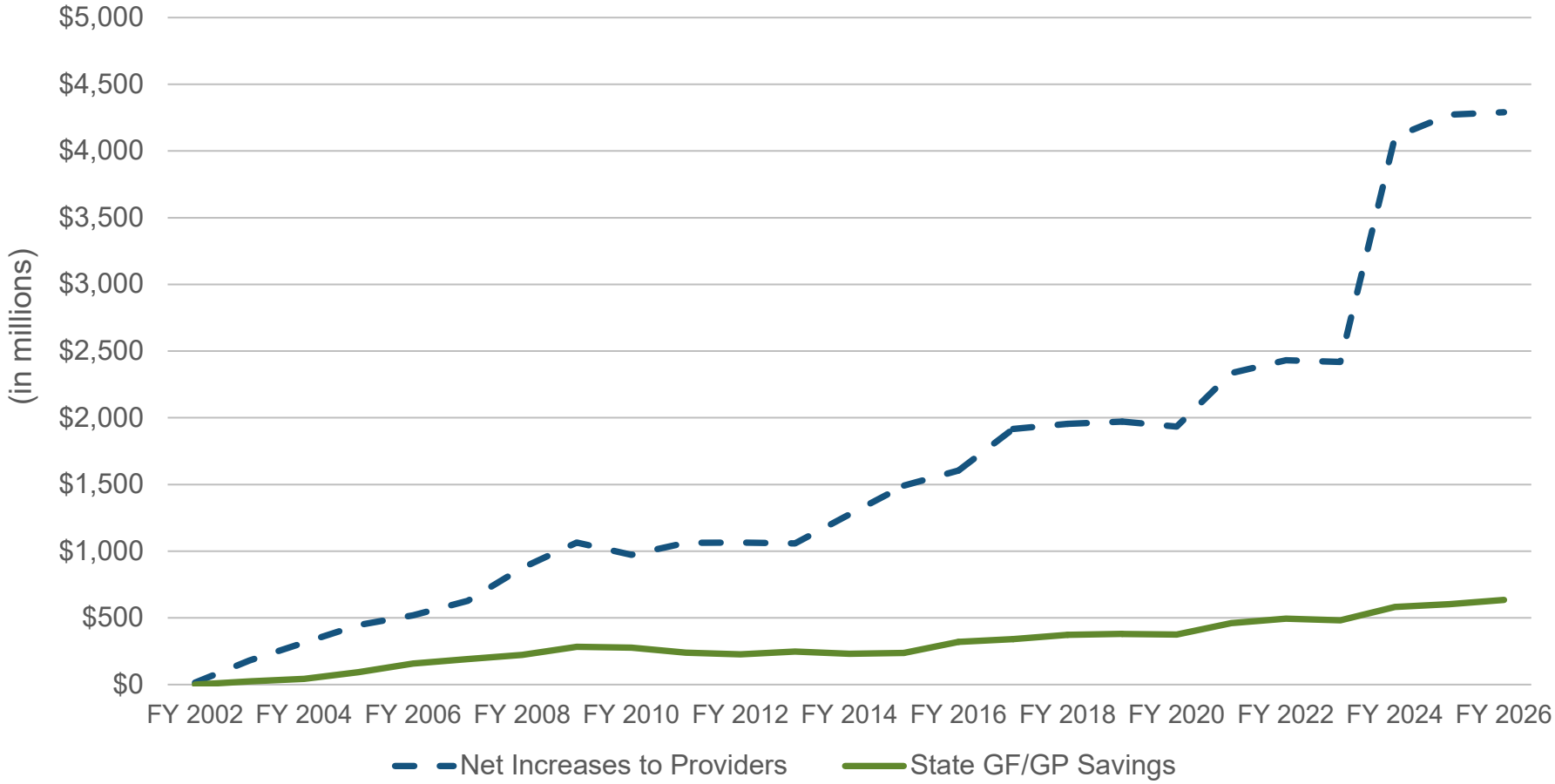
Note: Data are from FY 2024-25

State Medicaid Match Rate Portion

- For FY 2025-26, **$28.2 billion** in Gross Medicaid expenditures requires **$8.0 billion** in state match funds
- The largest source of state match funds is General Fund/General Purpose (GF/GP) revenue, at **$4.2 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 **$3.8 billion** in restricted or local funds appropriated for FY 2025-26
- State restricted fund sources include:
  - Provider assessments, known as the Quality Assurance Assessment Program (QAAP), levied on hospitals, nursing homes, and ambulance providers: **$2.49 billion**
  - Insurance Provider Assessment (IPA) Fund: **$628.2 million**
  - Medicaid Benefits Trust Fund (primarily from tobacco taxes): **$250.8 million**
  - Special financing funds from public and university hospitals: **$293.4 million**
  - Merit Award Trust Fund (tobacco settlement revenue): **$82.7 million**

QAAP Provider Increases and State Savings

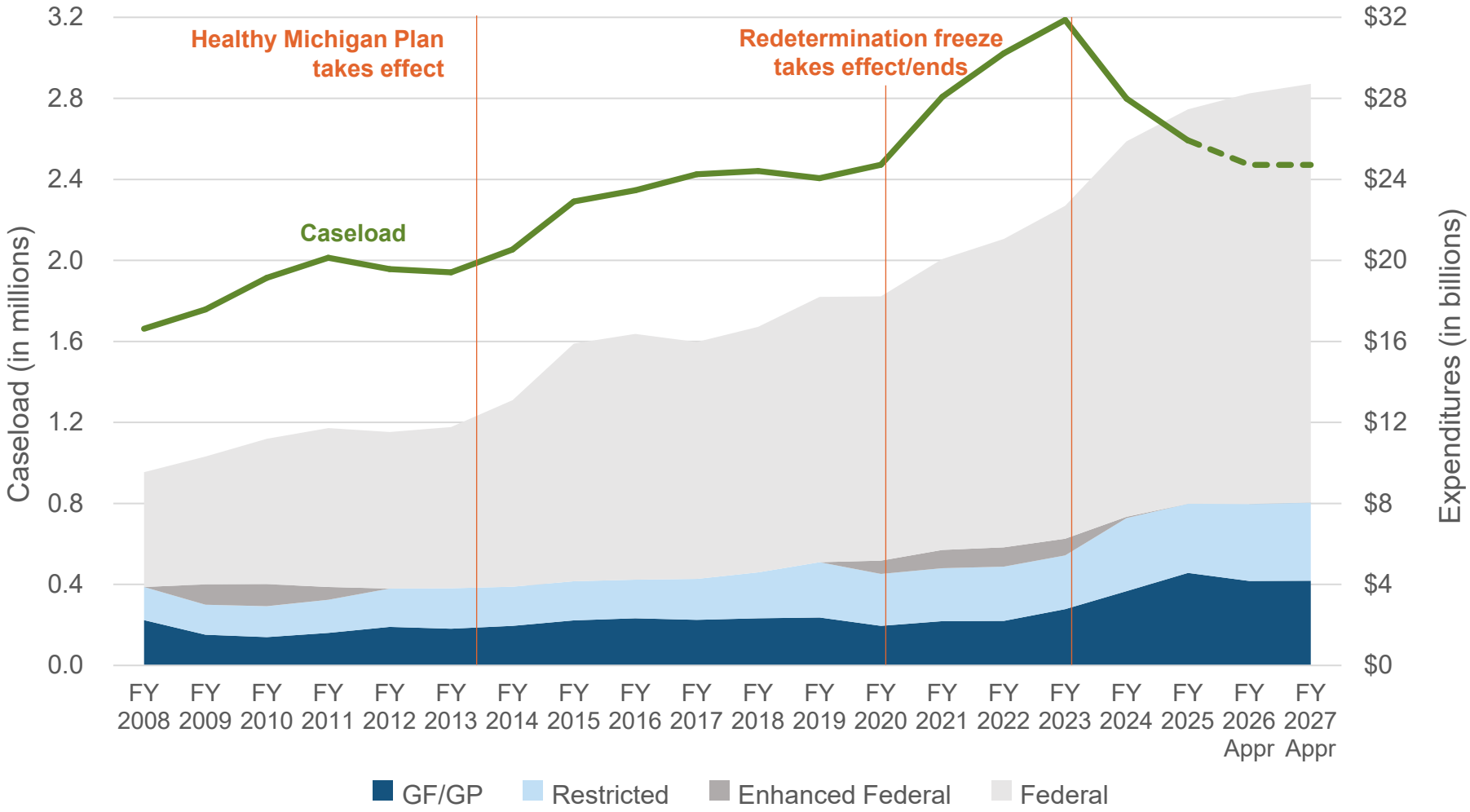
QAAP revenues are used to both increase Medicaid provider rates through supplemental Medicaid payments and offset GF/GP through statutorily established state retainers. The large increases to providers beginning in FY 2023-24 are related to changes implemented in the new managed care rule, which allowed QAAP payments to be indexed to commercial rates rather than Medicare.



Medicaid Budget Outlook

Medicaid Expenditures by Fund Source

Since FY 2007-08, the state's total Medicaid caseload has increased by **49%**, expenditures have increased by **200%**, and GF/GP has increased by **86%**, due to economic trends, the expansion under the Healthy Michigan Plan, and more recently the coronavirus pandemic redetermination freeze and subsequent redeterminations.



Enhanced Federal from American Recovery and Reinvestment Act of 2009 and Families First Coronavirus Response Act of 2020

GF/GP Support for Medicaid Expenditures

Three major factors have allowed GF/GP support for Medicaid to be held relatively flat through FY 2025-26:

1) The increased use of provider assessments and other state restricted revenue sources as state match. Restricted funds have grown from **$1.4 billion** to **$3.7 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 2006-07 rate of 56.38% (instead of 65.30%), the state would need to identify **$1.9 billion** in additional state matching funds

3) Initial 100% federal funding for the Healthy Michigan Plan population

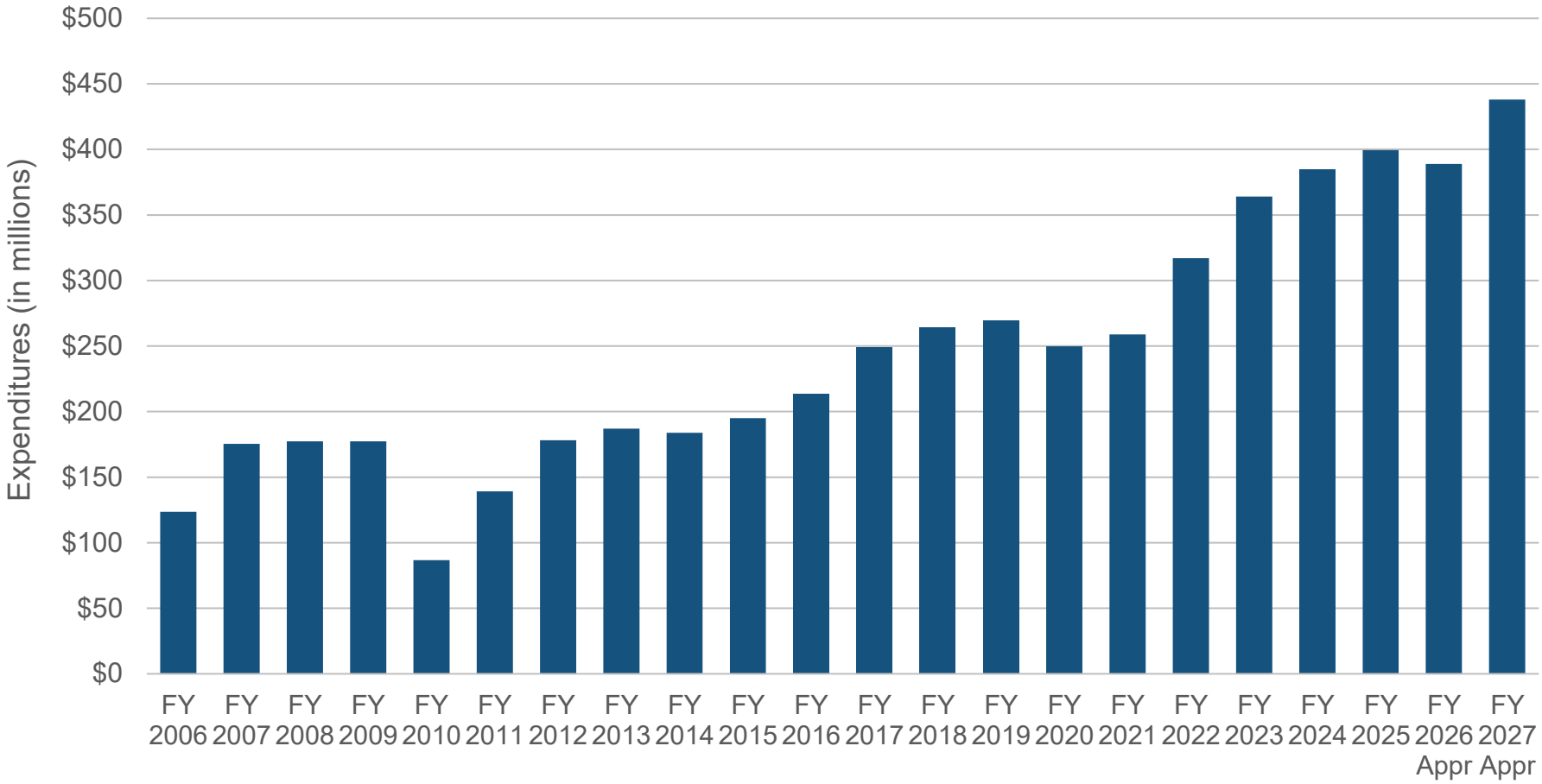
    - State match costs for the Healthy Michigan Plan begin on January 1, 2017. This resulted in GF/GP costs of **$2 million** for three-quarters of FY 2016-17, increasing to **$330.0 million** per year in FY 2025-26

    - Alternately, discontinuing Healthy Michigan Plan and shifting mental health, prisoner health care, and other costs back to the state would cost **$235 million** per year, plus the GF/GP cost of offsetting lost IPA revenue

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 and demographics.



Children's Special Health Care Services

- Covers special medical care and treatment for children up to the age of 26 with certain qualifying chronic and/or disabling diagnoses and adults with cystic fibrosis, certain hereditary blood coagulation disorders (e.g., hemophilia), or sickle cell disease
- 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 51,000 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 **$380 million** financed through GF/GP funding of approximately **$175 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

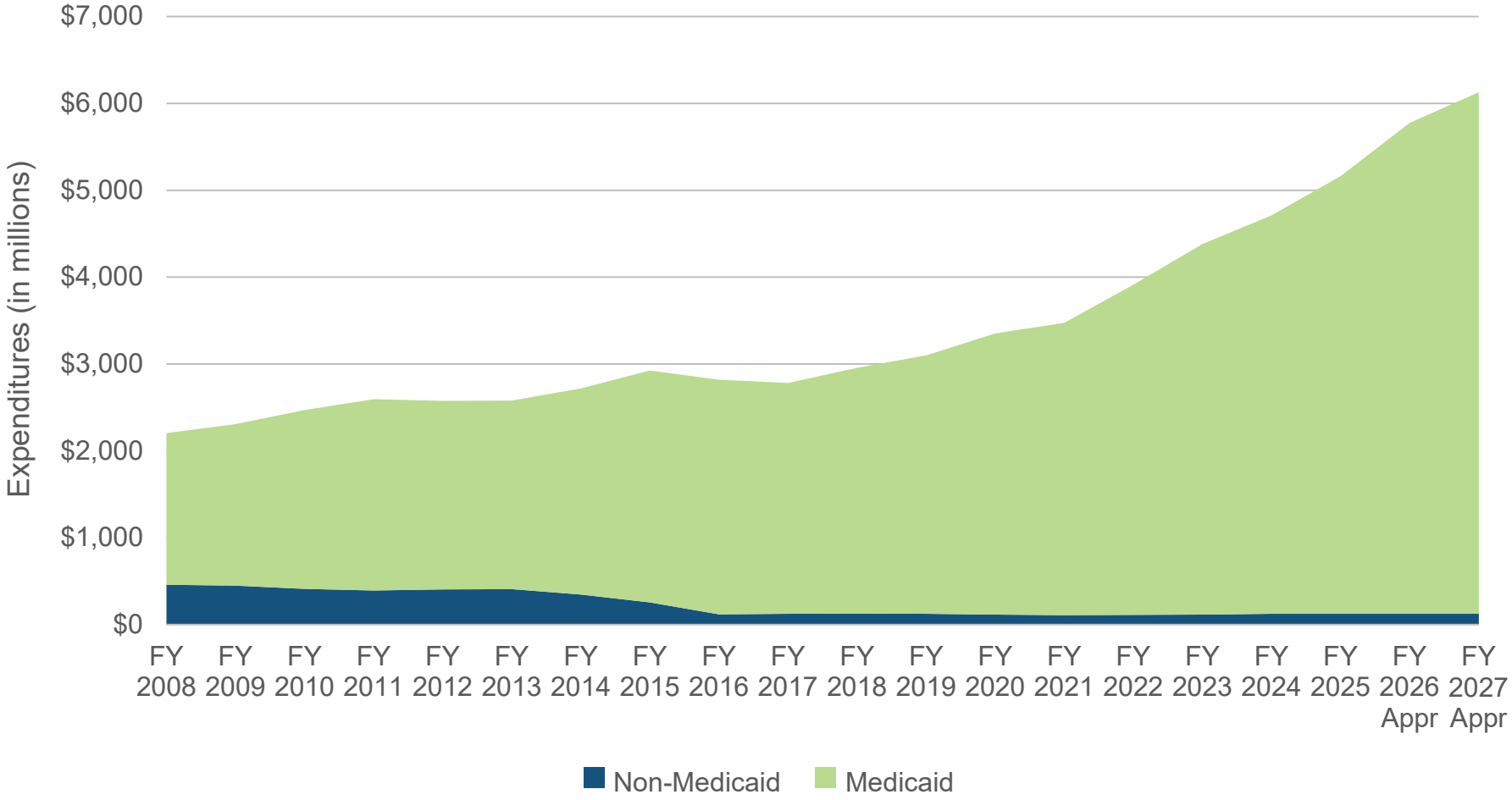
FY 2018-19: Increase of **$5.5 million** GF/GP to ensure revised funding distribution formula that utilizes population and poverty data and also includes a partial hold harmless provision

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
- 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

Mental Health Spending

Since FY 2007-08, total mental health spending has increased **178%**. 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. Recent Medicaid increases are from pandemic redetermination freeze and expansion of Certified Community Behavioral Health Clinics (CCBHCs).

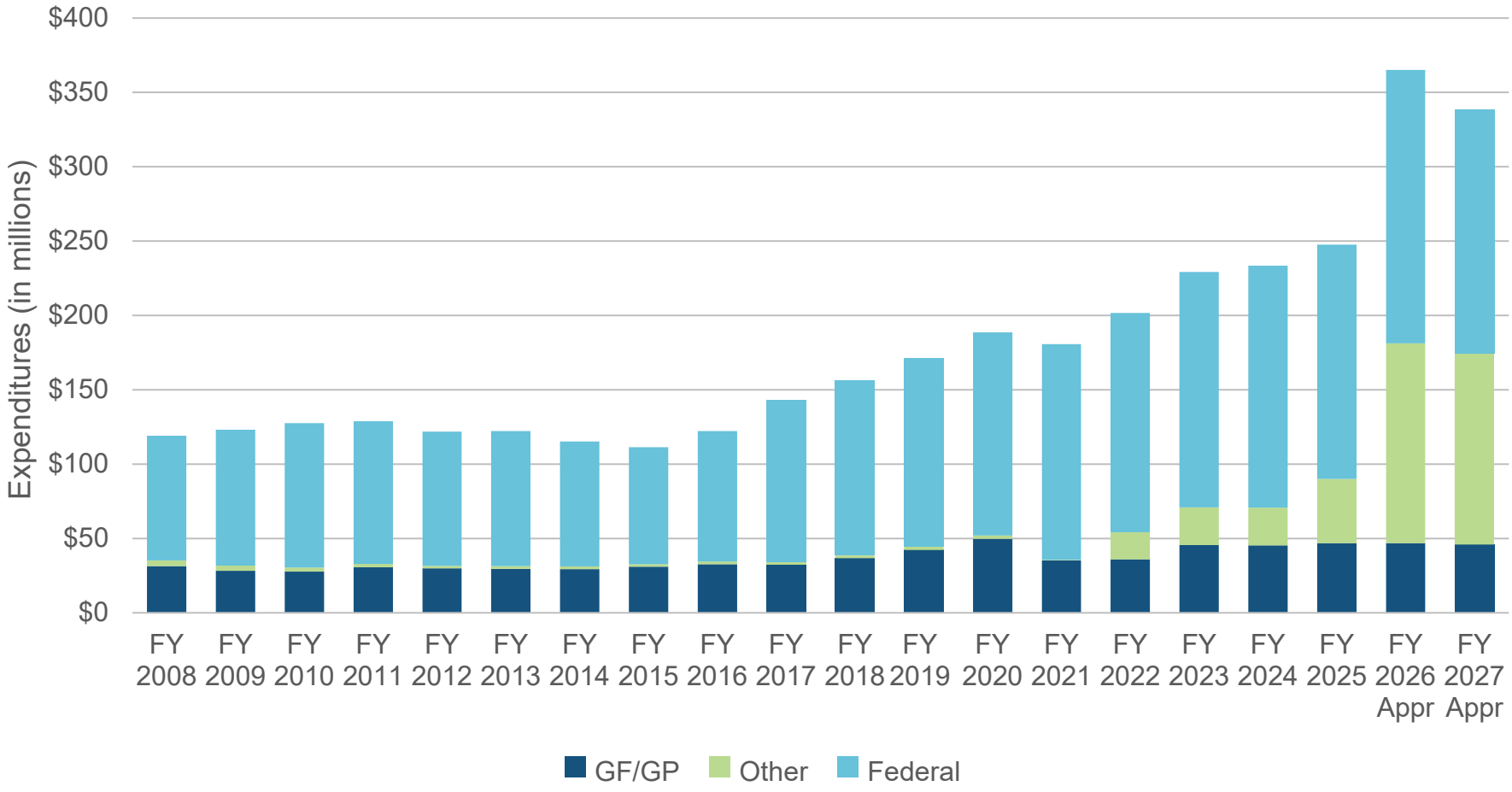


Substance Use Disorder Services

- 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 disorders
- 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 the funding for substance use disorder services comes from the federal Substance Abuse Prevention and Treatment Block Grant, federal State Opioid Response grant, and federal Medicaid reimbursements
- Opioid settlement funds, which are deposited into the Michigan Opioid Healing and Recovery Fund, are also beginning to support a larger portion of substance use disorder services

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 State Opioid Response grant and state restricted opioid settlement funds deposited into the Michigan Opioid Healing and Recovery Fund.

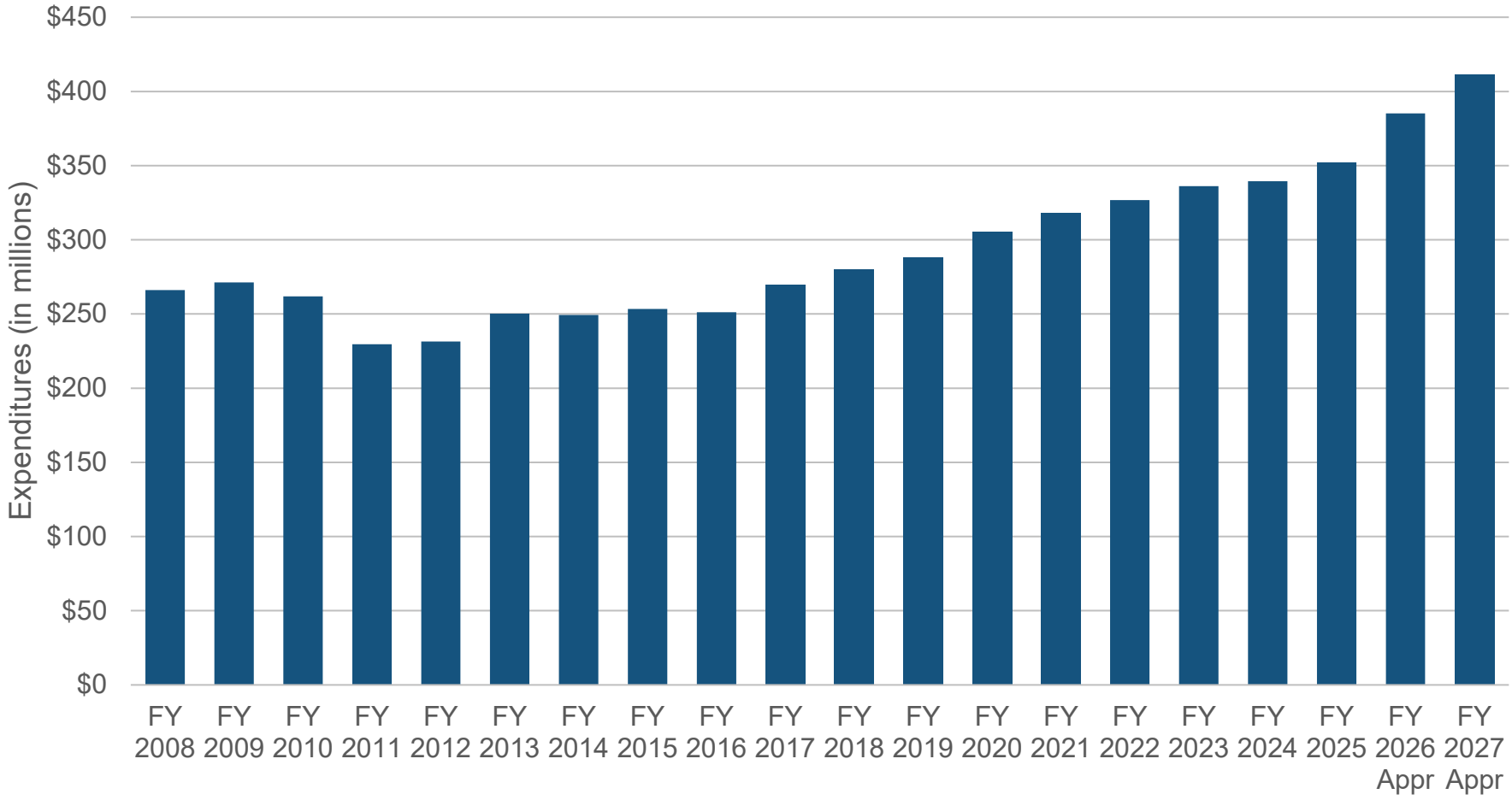


State Mental Health Facilities

- The state has two state-operated psychiatric hospitals for adults
  - Caro Regional Mental Health Center, located in Caro
  - Kalamazoo Psychiatric Hospital, located in Kalamazoo
- The state has one state-operated psychiatric hospital for adults and children
  - Walther P. Reuther Psychiatric Hospital, located in Westland
  - A new Southeast Michigan Psychiatric Hospital, located in Northville, will replace Hawthorn Center (recently demolished) and Walter P. Reuther with an estimated 264-bed capacity in the beginning of FY 2026-27
- DHHS is responsible for administration of the Forensic Center in Saline, created for criminal defendants ruled incompetent to stand trial and/or acquitted by reason of insanity

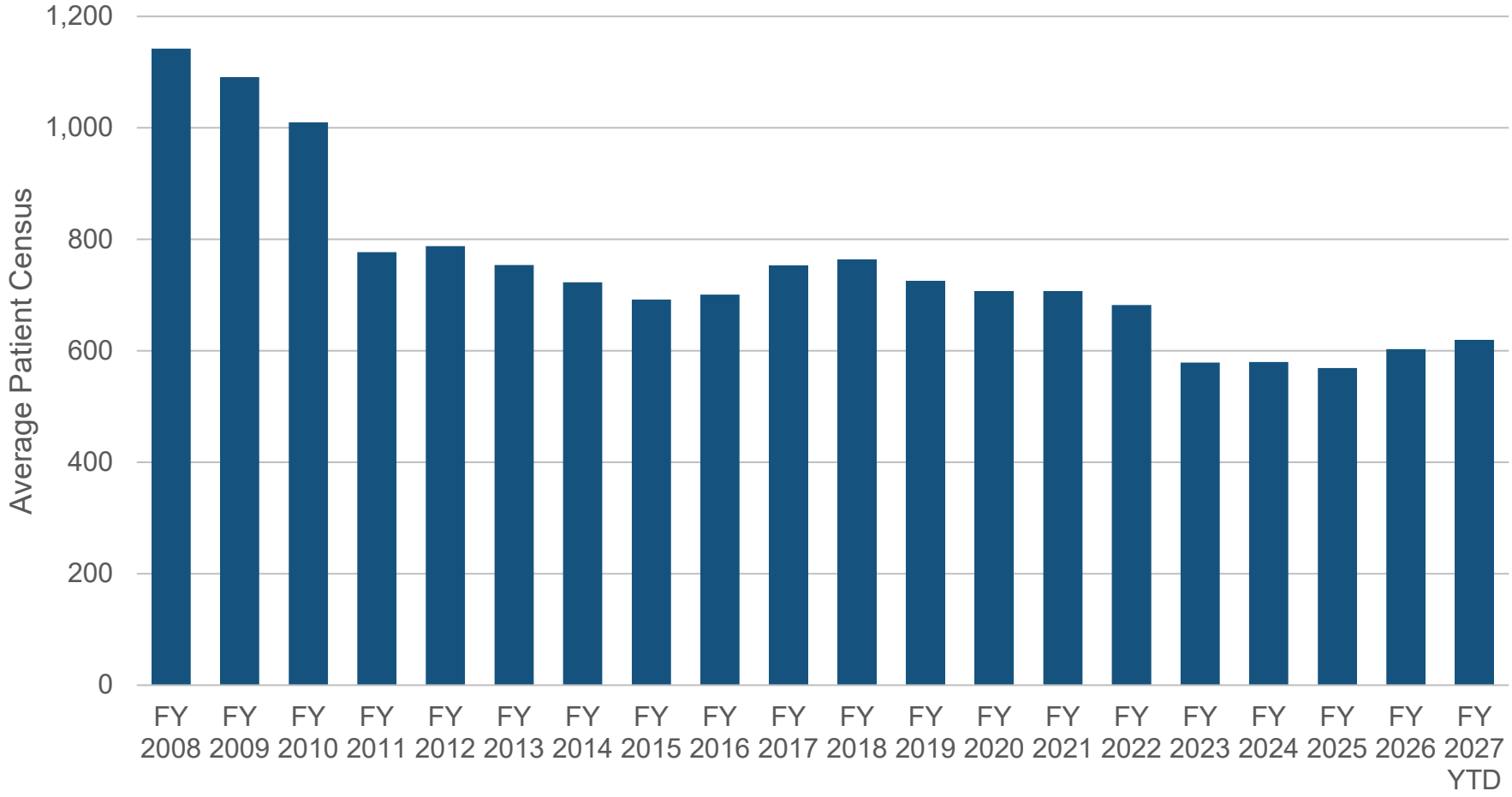
State Mental Health Facility Expenditures and Authorizations

Expenditures for state mental health facilities fluctuated around **$250 million** from FY 2007-08 through FY 2015-16. Starting in FY 2016-17, expenditures began to increase with recent costs exceeding **$400 million (or 64%)** to support operations at the new hospital.



Patients in State Mental Health Facilities

The number of patients in state-operated mental health facilities fell from FY 2007-08 through FY 2010-11 due to facility closures and transfer of responsibilities for forensic prisoner mental health services to the Department of Corrections. While facility expenditures have increased since FY 2016-17, the number of patients have declined by **18%.**



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