State Notes

TOPICS OF LEGISLATIVE INTEREST

Summer 2014

Community Mental Health non-Medicaid Services Funding Adjustments
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Summary

Due to the implementation of Medicaid expansion, the Community Mental Health (CMH) non-Medicaid line item in the budget for the Michigan Department of Community Health has been reduced significantly in fiscal year (FY) 2013-14, from the original appropriation of $283.7 million to $194.7 million plus a $12.0 million reserve (total appropriation of $206.7 million), a net reduction of $77.0 million. This reduction was made because many of the low-income uninsured people served by and services provided by the Community Mental Health Services Programs (CMHSPs or CMHs) became eligible for Medicaid reimbursement due to the expansion, which took effect on April 1, 2014.

For FY 2014-15, there is a larger reduction in CMH non-Medicaid funding as Medicaid expansion will be in effect for the entire fiscal year, not just the latter six months of the year. The CMH non-Medicaid services line in the enacted FY 2014-15 budget is $97.1 million, a reduction of $186.6 million from the pre-expansion funding level.

There has been a dispute between the CMHs, as represented by the Michigan Association of Community Mental Health Boards (the "CMH Association"), and the Snyder Administration as to how much funding is necessary to maintain the pre-expansion level of services to those individuals not eligible for expansion and those services not covered by Medicaid. The CMHs have stated that they believe $141.1 million ($140.0 million plus $1.1 million in State facility transfer adjustments) is needed for services full-year, reflecting a $142.6 million General Fund/General Purpose (GF/GP) reduction. As noted, the FY 2014-15 budget includes $97.1 million in funding for the CMH non-Medicaid services line.

Based on that estimate the CMH Association has argued that an appropriate savings estimate for the latter half of FY 2013-14 would be roughly half of the $142.6 million figure, or $72.0 million GF/GP. That estimate would justify a reduction in the FY 2013-14 non-Medicaid line from $283.7 million to $211.7 million, compared with the $206.7 million provided by the Legislature.

As such, in FY 2014-15 there is a gap of $44.0 million GF/GP ($97.1 million vs. $141.1 million) between the enacted FY 2014-15 CMH non-Medicaid line item and what the CMH Association believes is necessary. In FY 2013-14, the gap is much smaller, $5.0 million ($206.7 million vs. $211.7 million).

Over the last two months, there have been a number of communications to legislators and news reports stating that CMHs have had to cut back programming and have eliminated contracts due to inadequate resources in FY 2013-14.

Given that the gap between the amount requested by the CMHs for FY 2013-14 and the amount appropriated is $5.0 million out of $211.7 million, the Senate Fiscal Agency can find no evidence that these reported FY 2013-14 reductions are based on a lack of sufficient CMH non-Medicaid funding.

The difference between the CMH's estimate and the funding provided by the Legislature is less than 3.0% of the total funding. It is unclear how one can argue, even assuming that the CMHs' full-year estimate that $140.0 million is needed is correct, that the State has not provided the CMHs with just about every dollar the CMH Association requested for FY 2013-14.

The State has implemented rebasing for pre-expansion Medicaid behavioral health services provided by Pre-paid Inpatient Health Plans (PIHPs) and that has adjusted funding up and down for various PIHPs. Those funding changes are completely unrelated to the adjustments made to CMH non-Medicaid services due to expansion of Medicaid. It is possible that some PIHPs have reduced contracts for pre-expansion Medicaid services and that those reductions are being blamed on the Medicaid expansion adjustments, but that blame is misplaced.

It is also important to note that funding has been advanced to CMHs to help with cash flow issues related to retroactive Medicaid eligibility, that there have been meetings between the Department of Community Health (DCH) and the CMHs to help address concerns going back several months, and that the CMHs, collectively, have a fund balance of over $143.9 million to help address cash flow issues.

That being said, the gap between the FY 2014-15 appropriation and the CMH estimate, $44.0 million, is quite significant and there is no question that there will have to be discussions as to what is an appropriate amount of funding. Unlike the case in FY 2013-14, there is plenty of time for these discussions to take place and, at some point this fall, there should be clearer indications as to the GF/GP savings achieved from the transfer of populations and services to Medicaid expansion.

Introduction and Background

Over the past several months, there have been a number of concerns expressed about Community Mental Health funding, in particular CMH non-Medicaid funding, subsequent to the implementation of Public Act 107 of 2013, commonly known as "Medicaid expansion" or the Healthy Michigan Plan.

The CMH system provides behavioral health services to low-income people throughout the State. Most of the low-income people covered are eligible for Medicaid and receive their services via a managed care model through PIHPs. Pre-paid Inpatient Health Plans are groups of CMHs. There are numerous low-income people who were not eligible for Medicaid prior to the implementation of expansion and many who still are not eligible. There are also services for which Medicaid does not provide reimbursement. Funding for those people and services is provided through the CMH non-Medicaid services line item.

In the original FY 2013-14 DCH budget, $2,152.9 million was appropriated to the PIHPs for Medicaid mental health services and $283.7 million (all GF/GP funding) was appropriated to the CMHs for CMH non-Medicaid services.

Medicaid Expansion

The implementation of Medicaid expansion has changed the dynamic significantly. Medicaid expansion provides Medicaid coverage to otherwise-uninsured adults with incomes under 138% of the Federal poverty level, which is just over $16,000 for a single adult. It should be noted that children under 138% of poverty are already categorically eligible for "regular" Medicaid, so the expansion of Medicaid applies only to adults.

Furthermore, the Federal government, through the end of calendar year 2016, will pay 100% of service costs for the expansion population. After that point, the rate will drop to 95% and, by calendar year 2020, to 90%. This means that during FY 2013-14, FY 2014-15, and FY 2015-16, the State will not incur any costs for services to the expansion population.

A significant number of the low-income adults who receive services paid for from the CMH non-Medicaid line are now eligible for expansion Medicaid. The costs for the Medicaid-covered CMH services they receive are reimbursed with Medicaid dollars rather than CMH non-Medicaid dollars. In effect, a substantial portion of the services paid from the $283.7 million GF/GP CMH non-Medicaid line is now paid with Medicaid expansion dollars.

Medicaid Eligibility, Retroactivity, and Cash Flow

The reimbursement process is not as simple as switching funding streams from CMH non-Medicaid to the new "Healthy Michigan Plan - Behavioral Health" line item. Those eligible must enroll in the program.

Individuals who apply for Medicaid and are deemed eligible, are eligible retroactive to the date they applied. While the eligibility determination process may take time, the cost of services provided to such an individual is fully reimbursed from the date of application. For example, if a person shows up at a CMHSP on July 24, 2014, and it works with the person to apply for Medicaid on that date and the person is deemed eligible on August 3, 2014, the CMHSP will be fully reimbursed for costs incurred from July 24 onward.

Therefore, if an uninsured person shows up at a hospital, a CMHSP, or another health facility seeking medical services, whether the person seeks treatment for physical or behavioral health issues, it is very much in the interest of the provider to determine whether the person may be Medicaid-eligible – either for "regular" Medicaid or for expansion Medicaid.

This means that it is very important for a health provider to have a person apply for Medicaid immediately, especially if the person is facing an emergency situation, needs hospitalization, or has a potentially costly pharmaceutical issue. Only by taking that step can the provider be assured that it will be fully reimbursed if and when the person is deemed eligible for Medicaid.

The situation for hospitals and other physical health providers is a bit different from the situation faced by CMHs. A hospital does not have public funding available to directly cover services to a low-income uninsured person who shows up at the emergency department. Therefore, a hospital's only way to cover the costs of services is for the person to apply for

Medicaid. While retroactive reimbursement is not immediate, the hospital will eventually receive payment for the services.

Unlike hospitals, CMHs do have a pool of public non-Medicaid funds to provide services to these potentially Medicaid-eligible individuals. However, the CMHs are much better off, in spite of that pool, if a person applies for Medicaid on the day he or she seeks services. That way, while the CMHs must use their own resources to provide services until a person is deemed Medicaid-eligible, they will be reimbursed for those costs. Every day that a CMHSP delays in having a person apply is one more day when it has to use its own non-Medicaid resources without subsequent reimbursement. Therefore, it is just as important for CMHs to have a likely Medicaid-eligible client apply for Medicaid immediately as it is for hospitals.

The issue for CMHs during the application determination process is not reimbursement for services for those eligible for Medicaid expansion; it is cash flow. In other words, as numerous regular clients who became eligible for Medicaid on April 1, 2014, showed up in early April and applied for expansion Medicaid, the CMHs had to use their own resources to provide services until those people were deemed eligible. At that point, the State reimbursed the CMHs for the cost of those services retroactive to the date of application. However, that delay in reimbursement, especially at the start of expansion when hundreds of thousands applied and were added to the program, is a legitimate concern for CMHs. This cash flow issue is *not* a funding issue, but rather a timing issue, and the State addressed it by advancing CMH non-Medicaid and Healthy Michigan Plan dollars to the CMHs.

Assumed Savings

Governor Snyder, in proposing Medicaid expansion in his FY 2013-14 budget, released in February 2013, assumed large savings in the CMH non-Medicaid line. In a full-year situation, he assumed $203.9 million GF/GP savings in the CMH non-Medicaid line. Because his proposal assumed implementation of expansion on January 1, 2014, that is, three months into FY 2013-14, the Governor's savings assumption for FY 2013-14 in the CMH non-Medicaid line was $152.9 million GF/GP.

In effect, the Snyder Administration was predicting that about 72% of the spending and services provided in the CMH non-Medicaid line would be shifted over to expansion Medicaid. This would leave 28% of the funding to cover services that are not Medicaid reimbursed (like jail diversion), costs related to those spending down to be eligible for Medicaid, and individuals who receive services but are still not Medicaid-eligible even with expansion.

The Administration based its estimate on an examination of payments for CMH non-Medicaid services, the services provided (that is, whether they were services eligible for Medicaid reimbursement), and the likely eligibility status of those who received the services.

While at the time there were some concerns expressed about the magnitude of the projected savings, it appeared to be a good faith effort to get at a reasonable number.

Medicaid expansion was not included in the original FY 2013-14 DCH budget, but, in late August and early September 2013, House Bill 4714 was passed and signed into law by Governor Snyder as Public Act 107 of 2013. Not only did that Act expand the Medicaid program, it also contained appropriation adjustments for FY 2013-14 to reflect expansion of the program effective January 1, 2014.

Public Act 107 included a $152.9 million GF/GP reduction in the CMH non-Medicaid line to reflect the original nine months of CMH non-Medicaid savings assumed by Governor Snyder in his original FY 2013-14 budget. This reduced the CMH non-Medicaid line from $283.7 million to $130.8 million upon the effective date of the Act.

The legislation, however, after being passed by the Senate, did not receive immediate effect, so the program was not slated to be implemented until April 1, 2014, three months later than originally expected. Therefore, the savings were overestimated. Instead of nine months of savings totaling $152.9 million GF/GP, April 1 implementation meant six months of savings, projected by the Administration at $101.9 million GF/GP.

Because of this concern, Governor Snyder proposed a supplemental appropriation on October 15, 2013 (in supplemental letter 2014-1) to restore $51.0 million to the CMH non-Medicaid line. Thus, the Governor proposed total FY 2013-14 CMH non-Medicaid funding of $130.8 million plus $51.0 million, which, due to rounding, equaled proposed funding of $181.7 million.

CMH Concerns

In fall 2013, after the release of the supplemental letter, the CMH Association expressed concern that the Governor's proposed funding would not be adequate to cover CMH needs. It was at this point that the CMH Association estimated that, if the Governor's $51.0 million funding proposal were enacted, there would still be a shortfall of $30.0 million over the latter six months of FY 2013-14. This $30.0 million half-year shortfall estimate was based on the CMH Association's estimate of a $60.0 million full-year shortfall. Therefore, the CMHs asked the Legislature to provide $30.0 million more than the $51.0 million the Governor proposed in the FY 2013-14 supplemental, or $81.0 million. The CMH Association's proposal would have led to total FY 2013-14 CMH non-Medicaid funding of $211.7 million.

Discussions between the Snyder Administration and the CMHs

In December 2013 there was a meeting at the Capitol involving representatives of the State Budget Office, the DCH, the CMHs, and the Legislature. It was clear that there was still a large difference between the Administration and the CMHs on how much funding was needed to maintain the current level of programming.

The Administration noted that it was re-examining the basis of its original estimate that $80.0 million in full-year funding was adequate. The CMH Association reiterated its belief that the Administration had underestimated full-year need by $60.0 million and that, in the latter half of FY 2013-14, an additional $30.0 million would be necessary to maintain CMH programming.

Therefore, the CMHs again asked that the Governor's proposed FY 2013-14 supplemental for CMH non-Medicaid be increased from $51.0 million to $81.0 million.

Revised Administration Estimate

With the release of the FY 2014-15 DCH budget, the Snyder Administration revised its full-year estimate of how much CMH funding was necessary, increasing it by $16.0 million. In concert with that, the Administration increased its estimate of how much was needed in the FY 2013-14 supplemental by $8.0 million. Representatives of the Administration stated that they had looked at some of the concerns raised by the CMH Association and agreed that the Administration's original number had been too low to reflect actual funding need.

This adjustment reduced the "gap" between the Administration and CMH Association estimates to $44.0 million full year (FY 2014-15) and $22.0 million half year (FY 2013-14).

Adjustments in Senate Bill 608, the FY 2013-14 Supplemental

Because of the failure of the immediate effect vote on House Bill 4714, the funding for CMH non-Medicaid services would have run out in mid-March 2014. Thus, there was considerable pressure on the Legislature beginning in early February to enact a supplemental appropriation for the CMH non-Medicaid line. As noted above, the Governor's Recommendation of $51.0 million had been adjusted upward to $59.0 million, while the CMH Association estimated that $81.0 million was necessary to avoid cuts by CMHs.

As the proposed legislation was a Senate bill, there were discussions between the CMH Association and key Senators on how much to put into the bill. Senators proposed putting in $25.0 million above what the Governor originally recommended, or $76.0 million. This would be $5.0 million less than what the CMH Association proposed, but the CMH Association was supportive and stated its belief that the funding addressed the CMHs' concerns for FY 2013-14. Representatives of the CMH Association noted that they were still very concerned about the FY 2014-15 funding level, but felt that there was adequate time to address that as the FY 2014-15 budget moved forward.

The $25.0 million increase over the Governor's original proposal of $51.0 million, for a total of $76.0 million for the CMH non-Medicaid services line, was included in the Senate-passed version of Senate Bill 608.

The House of Representatives also included $25.0 million, but split the funding between $8.0 million directly allocated to the CMHs and $17.0 million in a CMH non-Medicaid contingent reserve, with a process set up to allocate the $17.0 million through the transfer process.

The final version of the supplemental bill, signed by Governor Snyder on March 14, 2014, as Public Act 34 of 2014, included $64.0 million directly allocated to the CMHs (the original $51.0 million plus $13.0 million) and $12.0 million in the contingent reserve. Boilerplate language gives the State Budget Director the authority to release funding from the reserve to the CMHs following documentation by the DCH that the funds are necessary to maintain

direct services to clients. The first release of these funds, $4.0 million, was announced on June 13, 2014.

The end result is that there was a total of $76.0 million added to the CMH non-Medicaid services line item in FY 2013-14, $51.0 million based on the original Executive supplemental request, $13.0 million in direct funding to CMHs, and $12.0 million in a contingent reserve. This compares to the CMH Association's request for $81.0 million in additional funding.

Implementation of the Healthy Michigan Plan

Enrollment in the Healthy Michigan Plan started on April 1, 2014. The first group to be enrolled was the approximately 65,000 individuals enrolled in the Medicaid Adult Benefits Waiver program, a limited coverage program funded with regular Medicaid dollars. Enrollment has increased rapidly since then and is now at approximately 300,000 individuals.

The implementation led to three key changes in financing for CMHs. First, there was a large reduction in funding for the CMH non-Medicaid line, from about $23.5 million per month to an average of about $11.0 million per month if all the money in the contingent reserve is distributed. Second, funding for behavioral health services for the Adult Benefits Waiver population, which averaged about $2.7 million per month, would be rolled into the Healthy Michigan Plan. Finally, there would be new funding to the PIHPs reflecting their prospective capitation costs and retroactive payments for enrollees in the Healthy Michigan Plan.

Cash Flow Issues

As noted above, a person who applies for Medicaid is eligible retroactive to the date of application. Therefore, if a regular high-cost behavioral health client shows up at a CMHSP for services and appears to be eligible for Medicaid expansion, it remains very much in the interest of the CMHSP to have that client apply. If that is done and the person is deemed eligible, then the CMHSP's costs for Medicaid-eligible services to that client will be covered with Healthy Michigan Plan dollars rather than other CMH resources, retroactive to the date of application.

While the retroactive eligibility does provide assurance that CMHs will eventually be reimbursed for services, there is still a cash flow issue.

There were many meetings between the Administration and the CMHs leading up to and through the implementation of the Healthy Michigan Plan. The Administration decided to advance CMH non-Medicaid dollars to help cushion the cash flow issue for CMHs. Furthermore, the Administration also advanced Healthy Michigan dollars for those who enrolled in early April.

As noted in the May 2, 2014, edition of "Friday Facts" from the CMH Association to its members, "[T]he Department of Community Health advised PIHPs they would be receiving an electronic funds transfer payment on April 30 for new Healthy Michigan members who have enrolled in the first three weeks of April. These payments brought the total state General Fund and Healthy Michigan payments in April to PIHPs and CMHs to a statewide

total of $26.9M and exceeds the March state General Fund and Adult Benefits Waiver payment total of $26.6M."

In other words, the cash flow problems and overall funding problems were addressed in April by the advancement of funding to the CMHs and PIHPs. This was the result of a collaboration between the DCH and the CMHs to try to help ensure a smooth rollout of the Healthy Michigan Plan. As noted by the CMH Association, "Healthy Michigan enrollment has been very successful in the first month, due in part to the efforts of CMHs, their provider organizations, and other healthcare partners in enrolling eligible persons who are in service or presented themselves for physical healthcare services during this month."

Reserve Funding

While an overall increase in funding flowed to CMHs in April (and, according to the Administration, in May), not every CMHSP or PIHP received more funding than in March. This was largely due to the varying rate of enrollment in the Healthy Michigan Plan. While there is no requirement that funding increase for all CMHs and PIHPs from the first day, it should be noted that, if there are cash flow problems, the CMHs and PIHPs generally have considerable financial reserves, with an aggregate CMHSP fund balance of over $143.9 million and an aggregate PIHP restricted risk reserve of over $137.4 million. Even in the case of cash flow issues, the CMHs and PIHPs do have resources to address problems as they arise.

The Picture for FY 2013-14

Needless to say, these advanced payments and reserves described above will not be sufficient to address any long-term funding shortfalls caused by insufficient appropriations. However, potential shortfalls are an issue for FY 2014-15, not FY 2013-14.

There appears to be scant evidence that the implementation of the Healthy Michigan Plan will cause any meaningful funding shortfalls for CMHs in FY 2013-14 and certainly not any funding shortfalls that would justify cuts to subcontractors. The following factors support this statement:

- The CMH Association asked for a CMH non-Medicaid supplemental of $81.0 million and the Legislature, combining direct funding and the contingent reserve, provided $76.0 million. Total funding, $206.7 million, is 97.6% of the total funding sought by the CMH Association, $211.7 million. The latter figure is at the high end of the range of estimates of the amount necessary to continue non-Medicaid services at the level in place prior to implementation of the Healthy Michigan Plan.
- Low-income individuals with behavioral health needs who show up at CMHs or hospitals should be and appear to have been signed up for the Healthy Michigan Plan. Eligibility is retroactive to date of enrollment, so Medicaid-covered costs for these individuals will be reimbursed fully.

- The retroactive nature of the enrollment process means that CMHs and PIHPs could face cash flow problems, but the State advanced funding in April and May to help address those issues. The result was, as the CMH Association has noted, an increase in total funding from pre-expansion levels.
- To the extent individual CMHs and PIHPs face cash flow issues, they have considerable financial reserves to help them get through the transition.

The Picture for FY 2014-15

At this point, the outlook for FY 2014-15 is considerably different than the situation in FY 2013-14. The enacted FY 2014-15 budget included $97.1 million for CMH non-Medicaid services. The CMH Association has argued that the funding need is $141.1 million (including $1.1 million in State facility adjustments on top of the original CMH Association request for $140.0 million). The difference between the appropriation and what the CMHs argue is needed is $44.0 million.

Since FY 2014-15 situation is time. FY 2014-15 does not begin until October 1, 2014, however, there are over two months during which progress can be made toward identifying what costs are still being paid with non-Medicaid funds. By October 1, the Healthy Michigan Plan will have been in place for six months and chronic behavioral health patients who are eligible should have been signed up, so it should be clearer which individuals and which non-Medicaid reimbursed programs still have to be funded with CMH non-Medicaid dollars.

Therefore, while one cannot determine at this point just what is the appropriate level of funding for FY 2014-15, the size of the gap between the appropriation and what one of the prime actors believes is needed means that discussions must continue. It also will be important for members of the Legislature to be part of these discussions, so that the Legislature is fully informed before taking any actions to adjust funding.

Rebasing of Medicaid Pre-Paid Inpatient Health Plan Rates

There is an issue, completely unrelated to the implementation of the Healthy Michigan Plan and adjustments to CMH non-Medicaid funding, that has affected public behavioral health funding. At the start of FY 2013-14, the DCH began to rebase behavioral health payment rates for "regular" Medicaid, that is, funding to the PIHPs for the pre-expansion Medicaid population. The rebasing has changed the allocation of funding among the PIHPs to "reduc[e] disparities within the [PIHPs]". Some PIHPs, in particular Detroit-Wayne, Macomb, and Oakland, have seen their funding reduced below what it would have been had the previous funding methodology been retained. Other PIHPs have seen increases in funding.

It certainly is possible that these changes have led PIHPs to end or reduce some contracts for services to pre-expansion Medicaid clients. The PIHP rebasing, however, is tied to pre-expansion Medicaid funding and the pre-expansion Medicaid population. The PIHP rebasing is not related at all to the implementation of Medicaid expansion or the various adjustments to the CMH non-Medicaid line. Any rebasing-related contractual changes cannot be attributed to the CMH non-Medicaid line or Medicaid expansion.

Conclusion

There are legitimate reasons to be concerned whether FY 2014-15 funding for CMH non-Medicaid services will be sufficient to maintain services at the same level as in prior years. Discussions based on updated information, as the Healthy Michigan Plan is implemented, will be crucial to help provide an estimate of what is needed to maintain the prior-year service level in FY 2014-15. The Legislature will have a key role in both the discussion and the implementation of any changes.

The FY 2013-14 situation is different. There does not appear to be any basis to tie the implementation of the Healthy Michigan Plan to reported FY 2013-14 reductions by CMHs and PIHPs in contracts and services. The total funding for CMH non-Medicaid services provided by the Legislature is very similar to what was requested by the CMH Association, the DCH has taken steps to advance funding to avoid cash flow problems, and CMHs and PIHPs have considerable financial reserves.

The Senate Fiscal Agency will continue to monitor any discussions and proposed adjustments to mental health funding.