

Executive Summary

Dimensions of systemic underfunding of Michigan's public mental health system:

Michigan's public mental health system is one of the most comprehensive and advanced in the country. However, over the past several years, a number of financing decisions, by the State of Michigan, have systematically eroded the ability of Michigan's public mental health system to meet the needs of Michiganders who have come to rely upon the system while similarly eroding the fiscal stability of this public system.

These practices, causing "death by a thousand cuts", include the following:

1. Funding to the public system does not reflect actual and growing need: While the demand for wide range of mental health services, in communities across Michigan, has grown dramatically over the past several years, the funding for the public mental health system responsible for meeting those needs has not. Some of these needs include: **addressing the opioid crisis, preventing suicide and respond to mental health crises, serving children and adolescents with autism, preventing arrest and incarceration, preventing homelessness, keeping kids in school safe and successful, support persons with disabilities to live in the community.**

2. Funding to the public mental health system does not reflect real and appropriate costs of care: While the communities' needs and expectations have grown, the Medicaid funding for Michigan's public mental health has remained insufficient to meet these needs. The factors behind this underfunding include: **insufficient funding of Healthy Michigan Plan, high cost persons enrolled in Healthy Michigan without corresponding revenue, rates do not reflect minimum wage requirements.**

The Impact of mismatch of revenues with actual needs and real costs: The fact that the funding provided to the state's public mental health system is far below that needed to meet the growing mental health demands of Michiganders, as outlined above, threatens access to care the fiscal stability of the state's public mental health system. **Even with a very low administrative rate (6.1%; far lower than that of the private Medicaid health plans), the underfunding of the public mental health system caused a deficit of \$133 million in FY 2017.**

3. Failure of the state to fund federally required contributions to public mental health system's risk reserves: For the past twenty years, the Medicaid funding provided to the state's public mental health system **did not include the federally required risk-reserve contribution component** that would have allowed Michigan's public mental health system to build and retain the necessary risk reserves – **reserves necessary for any risk-bearing managed care entity.**

If the Medicaid rates paid to the public mental health system had included even a modest component (2%) to provide for contributions to reserves and risk margins, the public mental health system would have **received \$50 million more in Medicaid payments in the current fiscal year**, FY 2018 and nearly \$700 million over its twenty-year history, providing reserves sufficient to weather a range of fiscal storms.

4. Inability of the public system to retain savings of sufficient size to ensure fiscal stability: The PIHPs (the public health plans that receive the Medicaid payments from the state) are prohibited from

holding sufficient risk reserves. Similarly, the **CMHs are prohibited from retaining any Medicaid savings** that they generate through efficiencies and effective clinical practices. These savings, **permitted for any other healthcare provider**, would allow the CMHs to invest in meeting community needs and ensuring their clinical and fiscal stability.

5. Inappropriate state demand that county funds be used to close Medicaid gap: County funds are inappropriately drained from the system to cover state Medicaid obligations and away from their intended use – to fund services to Michiganders without Medicaid coverage.

- For the past decade, the State of Michigan has required that the public mental health system use of county dollars (through what is called “local match draw down” to underwrite part of the state’s share of the Medicaid mental health budget. Over \$25 million is annually used to cover this obligation.
- Over the past several years, in lieu of holding up its end of the risk-sharing arrangement that MDHHS has with the state’s public mental health system, **MDHHS has demanded that county funds be used to cover the Medicaid costs not covered by state Medicaid dollars**

6. General Fund short fall: While long insufficient, the State General Fund (non-Medicaid) support for the public mental health system and its ability to meet increasing community demand has fallen off dramatically. The **60% cut to the GF revenues of the state’s CMHs**, in 2014 and 2015, led to **10,000 fewer persons receiving services**. As a result of this cut, **\$7.50 per person per year is available**, to the public mental health system, to provide mental care to the 8 million Michiganders without Medicaid coverage.

Concrete actions to address the systemic underfunding of Michigan’s public mental health system

1. Medicaid rates set to match demand and costs: Set the Medicaid rates to the state’s public mental health system (the process that provides over 90% of the funding for this system) to **reflect the actual and projected growth in demand for and the real costs** of providing the services associated with Michigan’s Medicaid mental health benefit.

2

2. Medicaid rates to include contribution to risk reserve: Include, in the Medicaid rates to the state’s public mental health system the federally required contribution to risk reserves at a level sufficient to allow for the fiscal soundness of the public mental health system,

3. Allow the public mental health system to hold sufficient risk reserves: Allow the state’s public Medicaid mental health/specialty health plans (the Prepaid Inpatient Health Plans; PIHPs) to **hold risk reserves of the size that would be held by any risk-bearing organization**. Allow the **CMHs to retain and reinvest any Medicaid savings** that they generate through efficiencies and effective clinical practices.

4. Free up local dollars to meet unmet non-Medicaid needs, by halting the inappropriate drain of local dollars to fulfill state Medicaid obligations: eliminate the Local Match Draw Down requirement; assume the appropriate state role in ensuring the soundness of the state’s Medicaid mental health system by **halting the demand, made by MDHHS, that counties and CMHs provide local dollars to close the mandated Medicaid entitlement funding gap** caused by the systemic underfunding of Michigan’s public mental health system.

5. Restore General Fund dollars to the public mental health system: Restore the lion’s share of the State General Fund dollars cut from the CMH budget to ensure that persons, not covered by Medicaid, have access to needed mental health services.

Full analysis and recommendations:
Addressing the systemic underfunding of Michigan's public mental health system

Michigan's public mental health system is one of the most comprehensive and advanced in the country. However, over the past several years, a number of financing decisions, by the State of Michigan, have systematically eroded the ability of Michigan's public mental health system to meet the needs of Michiganders who have come to rely upon the system while similarly eroding the fiscal stability of this public system.

The Medicaid and General Fund support for Michigan's public mental health system – the state's Community Mental Health (CMH) centers, the Medicaid Prepaid Inpatient Health Plans ([PIHP], the public at-risk health plans formed and governed by the CMHs in their region), and the providers in the CMH and PIHP networks) has **been insufficient, for a large part of the last decade**, to meet growing community needs and cover the costs of meeting those needs.

This gap in funding dramatically impacts the state's **forty-six Community Mental Health centers**, the **ten Prepaid Inpatient Health Plans, hundreds of community-based private providers** in the CMH and PIHP networks, the **300,000 Michiganders who rely on this system** and the **tens of thousands of Michiganders unable to access this system**.

Dimensions of systemic underfunding of Michigan's public mental health system:

The causes of this insufficient funding - practices resulting in "death by a thousand cuts" - are outlined below. The lion's share of these costs is Medicaid-related – a program in which the State of Michigan pays less than 40% of the cost.

3

1. Funding to the public system does not reflect actual and growing need: While the demand for wide range of mental health services, in communities across Michigan, has grown dramatically over the past several years, the funding for the public mental health system responsible for meeting those needs has not. Some of these needs include:

- **Address the opioid crisis:** The need to address the state's opioid crisis through prevention and treatment accessible to persons in communities throughout the state. While the Healthy Michigan Plan (HMP) provided coverage, for the first time, for many Michigan residents in need of opioid treatment, in many communities, HMP funds are insufficient to meet these needs and the growing demand from those with HMP coverage.
- **Prevent suicide and respond to mental health crises:** As the attention of Michiganders has grown, over the past several years, relative to the risk of suicide, opioid abuse, and community safety needs, so has the demand for access to the public mental health systems' crisis response system – a system that is ready, 24 hours per day, 7 days per week, to assist community members in dealing with mental health crisis, for the prevention of suicide, recovery from substance use disorders and mental illness.
- **Serve children and adolescents with autism:** In many communities, the cost of providing evidence-based services to meet the growing demand for autism services is far above the revenues provided to cover these services
- **Prevent arrest and incarceration:** Communities, judges, law enforcement officials, policy makers, and families across the state have come to see the wisdom in providing mental health and support services to prevent persons, with mental health needs, from arrest and

- incarceration and supporting the return of persons to the community from the corrections/justice system.
- **Prevent homelessness:** Assisting persons with mental health needs has long been the responsibility of the state's public mental health system. The demand for these services has grown with the scarcity of affordable low-income housing and the desire by Michigan communities and policy makers to eradicate homelessness and stabilize housing for persons with mental health needs.
 - **Keep kids in school safe and successful:** Over the past several years, educators, state officials, and parents have called on the public mental system to increase the number of children and adolescents with serious mental health needs and to increase the intensity of those services – with the aim of improving academic success, reduce absenteeism, and ensure safe schools.
 - **Support persons with disabilities to live in the community:** Federal policies and public expectations have increasingly shifted to efforts designed to ensure that persons with intellectual/developmental disabilities and/or mental illness can live in their own homes and apartments within their home communities and participate in community activities of their choosing. The public mental health system is rapidly moving to embrace this policy change, long fostered by advocates, parents, and the persons served, but does not have the funding necessary to make this dream a reality.

2. Funding to the public mental health system does not reflect real and appropriate costs of care:

While the communities' needs and expectations have grown, the Medicaid funding for Michigan's public mental health has remained insufficient to meet these needs. The factors behind this underfunding include:

- **Insufficient funding of Healthy Michigan Plan:** The Healthy Michigan Plan (HMP) funding provided to the state's public mental health system **has been dramatically reduced, per enrollee, since the first year of the program.** These cuts in rates have left the public mental health system unable to fully meet the mental health needs of Health Michigan Plan enrollees while ensuring fiscal stability.
- **High cost persons enrolled in Healthy Michigan without corresponding revenue:** Over the last several years, a number of persons on Medicaid, with high cost mental health services needs, moved to the Healthy Michigan Plan. This change resulted in a 85% reduction in the rates paid, to Michigan's public mental health system. While some of that gap was made up – as a result of prolonged advocacy by the state's advocacy community, that gap remains and continues to grow as these high cost Medicaid enrollees continue to move the low revenue Healthy Michigan Plan.
- **Rates do not reflect minimum wage requirements:** the actuarial analysis has not reflected the impact of the last increase in the federal nor the recently adopted state minimum wage on the cost of Medicaid mental health services – a sizeable cost given the large number of community-based paraprofessionals who are core to the mental health service delivery system

Impact of mismatch of revenues with actual needs and real costs: The fact that the funding provided to the state's public mental health system is far below that needed to meet the growing mental health demands of Michiganders, as outlined above, threatens access to care the fiscal stability of the state's public mental health system.

This gap can be clearly seen in examining the public mental health system's Fiscal Year 2017 Medicaid financial reports. **The contrast is stark when compared with that of the private Medicaid health plans**, in Table 1, below.

Table 1: Comparison of Medicaid spending, in Michigan, by public mental health system and private managed care plans, Fiscal Year 2017ⁱⁱ

Fiscal Year 2017 (in millions of dollars)

	Michigan's public Medicaid mental health system	Private Medicaid managed care plans
Spent on services to persons in need of care	\$2,431.60 99.4%	\$7,657.70 89.8%
Spent on administration	\$148.2 6.1%	\$733.37 8.6%
Excess revenue (profit if a for-profit company)	-\$133.10 -5.4%	\$136.44 1.6%

5

As these data indicate, the **Michigan's public Medicaid mental health system was underfunded by \$133 million in Fiscal Year 2017**, with the total cost of meeting the demand, by Michiganders, for mental health services provided through the state's public mental health system exceeding the Medicaid funding provided that system by that amount. As Table 1 indicates, demand for mental health services drew over 99% of the funds that the PIHP system. **Even with a very low administrative rate (6.1%; far lower than that of the private Medicaid health plans), the underfunding of the public mental health system caused the deficit of \$133 million in FY 2017.**

During that same year, the **private Medicaid managed care plans took in profits of over \$136 million, while spending a smaller percentage on services to patients and spending a larger proportion on administration** than the public mental health system.

3. Failure of the state to fund federally required contributions to public mental health system's risk reserves: The fiscal stability of the state's public mental health system is weakened by the lack of a standard risk-based financing practice – a practice contained in risk-based contracts across the country and used with the state's private Medicaid managed care plans.

For the past twenty years, during the entire period during which Medicaid managed care has existed in Michigan, the Medicaid capitated rates provided to the state's public mental health system **did not include the federally required component that would have allowed Michigan's public mental health system to build and retain the necessary risk reserves** – reserves necessary for any risk-bearing managed care entity. The federal requirement for such a payment to the state's public mental health system is clear:

42 C.F.R. § 438.5.

(e) *Non-benefit component of the rate.* The development of the non-benefit component of **the rate must include** reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, **contribution to reserves, risk margin**, cost of capital, and other operational costs associated with the provision of services identified in §438.3(c)(1)(ii) to the populations covered under the contract.

This lack of appropriate financing has harmed the ability of the state's public mental health system to build and hold reserves sufficient to ensure that they could withstand the fiscal risk inherent in a managed care system – fiscal risk exacerbated by the insufficient benefit component of the rates.

As a result, the state's PIHPs now have half of the funds necessary to cover the risk corridor for which they are responsible. If the Medicaid rates paid to the PIHP/CMH system had included even a modest component (2%) to provide for contributions to reserves and risk margins, the PIHP/CMH system would have **received \$50 million more in Medicaid payments in the current fiscal year**, FY 2018.

If a similar contribution to reserves and risk margins had been included in the rates paid the public mental health system over the twenty years during which that system has served as the state's at-risk Medicaid managed care entity for behavioral health, the **public mental health system should have received approximately \$700 million in additional Medicaid revenue over that period** – funds that would have improved the ability of the public mental health system to adequately meet the needs of the Medicaid enrollees in their communities while ensuring fiscal stability of their organizations.

4. Inability of system to retain savings of sufficient size to ensure fiscal stability: Linked to the issue above, **the PIHPs** (the public health plans that receive the Medicaid payments from the state) **are prohibited from holding sufficient risk reserves.** These funds, if allowed to be of the size that would be held by any risk-bearing organization, would provide the capital needed to buffer the system from fluctuations in revenues and demand.

Similarly, the **CMHs are prohibited from retaining any Medicaid savings** that they generate through efficiencies and effective clinical practices. These savings, **permitted for any other healthcare provider**, would allow the CMHs to invest in meeting community needs and ensuring their clinical and fiscal stability.

5. Inappropriate state demand that county funds be used to close Medicaid funding gap: County funds are inappropriately drained from the system to cover state Medicaid obligations:

- a. For the past decade, the State of **Michigan has required that the public mental health system use of local dollars – the bulk of them coming from Michigan counties – to underwrite part of the state's share of the Medicaid mental health budget. Over \$25 million is annually used to cover this obligation.** These funds, if not used to meet these Medicaid obligations, would be used to meet the needs of the person, in communities across the state, without Medicaid coverage.
- B. Over the past several years, in lieu of holding up its end of the risk-sharing arrangement that MDHHS has with the state's public mental health system, **MDHHS has demanded that county funds be used to cover the Medicaid costs not covered by state Medicaid dollars.** These county funds are intended, by the county commissioners who allocate those funds nor by the taxpayers who provide those funds, to be used to meet mental health needs of persons without Medicaid coverage. These funds are not meant to be siphoned away to cover a state and federal obligation.

6. General Fund short fall: While long insufficient to meet community need, the State General Fund support for the CMH system and its ability to meet increasing community demand has fallen off dramatically. The 60% (\$200 million) cut to the GF revenues of the state's CMHs, in 2014 and 2015 (as a result of the state legislation that initiated the Healthy Michigan Plan) led to 10,000 fewer persons receiving services, during that year and since, even in light of the number of additional Healthy Michigan Plan enrollees served by the state's CMH system.ⁱⁱⁱ

As a result of this cut, **\$7.50 per person per year is available**, to the public mental health system, to provide mental care to the 8 million Michiganders without Medicaid coverage.

Concrete actions to address the systemic underfunding of Michigan's public mental health system

1. Medicaid rates set to match demand and costs: Set the Medicaid rates to the state's public mental health system (the process that provides over 90% of the funding for this system) to:

- **reflect the actual and projected growth in demand** for a range of mental health services. Those needs range from addressing the opioid crisis to preventing suicide; from keeping kids in school safe and successful to supporting persons with disabilities to live in the community.
- **reflect the real costs** of providing the services associated with providing the services included in Michigan's Medicaid mental health benefit. Those costs would include, among others, the cost of adequately funding the Healthy Michigan program, give the growing make-up of HMP enrollees and the related demand for services by those enrollees; the cost of complying with the state's minimum wage laws.

2. Medicaid rates to include contribution to risk reserve: Include, in the Medicaid rates to the state's public mental health system the federally required contribution to risk reserves at a level sufficient to allow for the fiscal soundness of the public mental health system,

3. Allow the public mental health system to hold sufficient risk reserves: The fiscal soundness of any organization, especially those with risk-based revenues, is dependent upon a sound risk reserve. To that end:

- Allow the state's public Medicaid mental health/specialty health plans (the Prepaid Inpatient Health Plans; PIHPs) to **hold risk reserves of the size that would be held by any risk-bearing organization.**
- Allow the **CMHs to retain and reinvest any Medicaid savings** that they generate through efficiencies and effective clinical practices.

4. Free up local dollars to meet unmet non-Medicaid needs, by halting the inappropriate drain of local dollars to fulfill state Medicaid obligations:

- **Eliminate the Local Match Draw Down requirement** that causes over \$25 million to be drawn from the funding for mental health services to Michiganders with Medicaid and meet that Medicaid matching requirement with state dollars.
- **Assume the appropriate state role** in ensuring the soundness of the state's Medicaid mental health system by **halting the demand, made by MDHHS, that counties and CMHs provide local dollars to close the mandated Medicaid entitlement funding gap** caused by the systemic underfunding of Michigan's public mental health system.

5. Restore General Fund dollars to the public mental health system: Restore the lion's share of the State General Fund dollars cut from the CMH budget to ensure that persons, not covered by Medicaid, have access to needed mental health services.

ⁱ In this document the term “public mental health system” refers to the system that is made up of the public Community Mental Health centers (CMHs), the public Medicaid Prepaid Inpatient Health Plans ([PIHPs] formed and governed by the CMHs), and the organizations that make up the PIHP and CMH provider network. The term “mental health” services, supports and systems, refers to the system that serves four distinct populations: persons with mental illness, children with emotional disturbance, persons with intellectual/developmental disabilities and persons with substance use disorders.

ⁱⁱ Data sources: Public mental health system data are drawn from “Fiscal 2017 Financial Status Report Summary”; Milliman; Summer 2018. Private managed care plan data are drawn from the FY 2019 Medicaid appropriations presentation and “Medicaid managed care financial results for 2017”; Milliman; May 2018.

ⁱⁱⁱ CMH Association’s Center for Healthcare Integration and Innovation study 9March 2017) “Impact of FY 2014 State General Fund budget cut to the state’s CMH system”