CHI²

Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

The perfect storm for fiscal distress in Michigan's mental health system:

The convergence of revenue and demand factors leading to the current fiscal stress in Michigan's public mental health system

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Executive Summary

The Center for Healthcare Integration and Innovation (CHI2) examined financial and service delivery records of Michigan's public mental health system – its Community Mental Health Centers (CMHs), Prepaid Inpatient Health Plans (PIHPs), and provider network - to determine the causes of the fiscal distress experienced by this system from Fiscal Year 2014 through FY 2019.

That study found that the convergence of a number of factors, starting in 2014 led to the sustained, system-wide revenue shortages and event deeper fiscal distress in a number of regions throughout the state.

The causes of **system-wide fiscal distress**, all tied to the changes initiated in 2014, were identified as:

1. State funding to public mental health system not keeping pace with increased demand and health care cost increases, from FY 2014 to the present
2. Deep cut of $200 million (representing a 60% cut) in General Fund support eliminated a key part of CMH fiscal infrastructure
3. Increased demand for substance use disorder services, especially opioid treatment
4. Dramatically expanding autism benefit without matching revenues
5. Revenue loss (an 80% cut in per enrollee revenues) due to high cost traditional Medicaid enrollees moving to low revenue Healthy Michigan Plan
6. Failure of the state to fund federally required contributions to public mental health system's risk reserves
7. Inappropriate state demand that local funds be used to close Medicaid funding gap

Causes of **uneven impact of fiscal distress** across the state - 2014 to the present

1. Widely disparate impact of FY 2016 and FY 2018 Medicaid ratesetting
2. Dramatic differences in demand for services not matched by funding
3. Insufficient number of higher-revenue Habilitative Support Waiver slots to meet high-cost needs

Structure of Michigan's public mental health system:

Michigan's public mental health system is made up of public, county-government based Community Mental Health centers (CMHs), the Prepaid Inpatient Health Plans (PIHPs; the public Medicaid specialty health plans formed and governed by the CMHs in the region covered by each PIHP), and the private provider organizations making up, along with the CMHs, the provider network managed by the CMHs and PIHPs. This system, operating under a risk-based Medicaid capitation-funding arrangement with a much smaller state General Fund funding component, manages and provides a wide range of mental health services to over 300,000 persons, annually, with serious mental illness, children with serious emotional disturbance, persons with intellectual and developmental disabilities, and persons with substance use disorders. This system converted from a Medicaid fee-for-service system to a risk-based capitated system in October 1997 and continues to operate as such a system currently.

Convergence of factors causing fiscal distress to the system

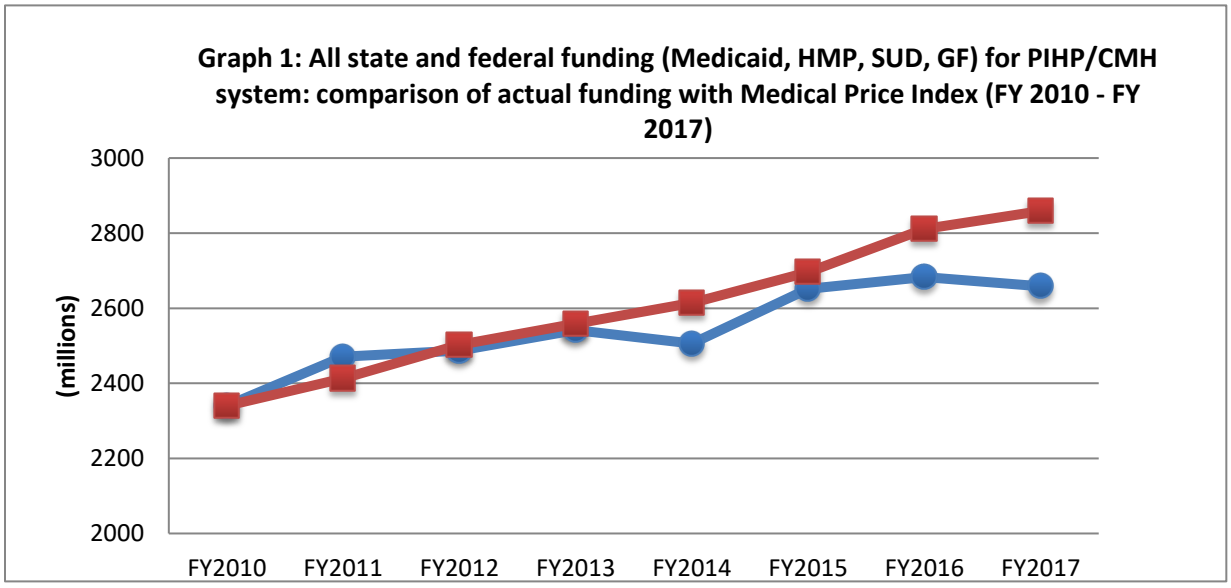
While the system was never flush with funding, this system was fiscally sound, under the risk-based capitated system until FY 2014. **However, from 2014 through 2019, a number of factors converged to cause systemic system-wide fiscal distress, with the impact of this fiscal distress being felt very unevenly across the state.**

During discussions with system observers and policy makers, in the spring of 2019, the question was raised regarding the factors, not present in the more distant past (from 1998 through 2014), but that are the causes of the fiscal stress in the state's CMH/PIHP system, starting in FY 2014 through the present and most acutely from FY 2016 through the present. This is the central question around which this report is built.

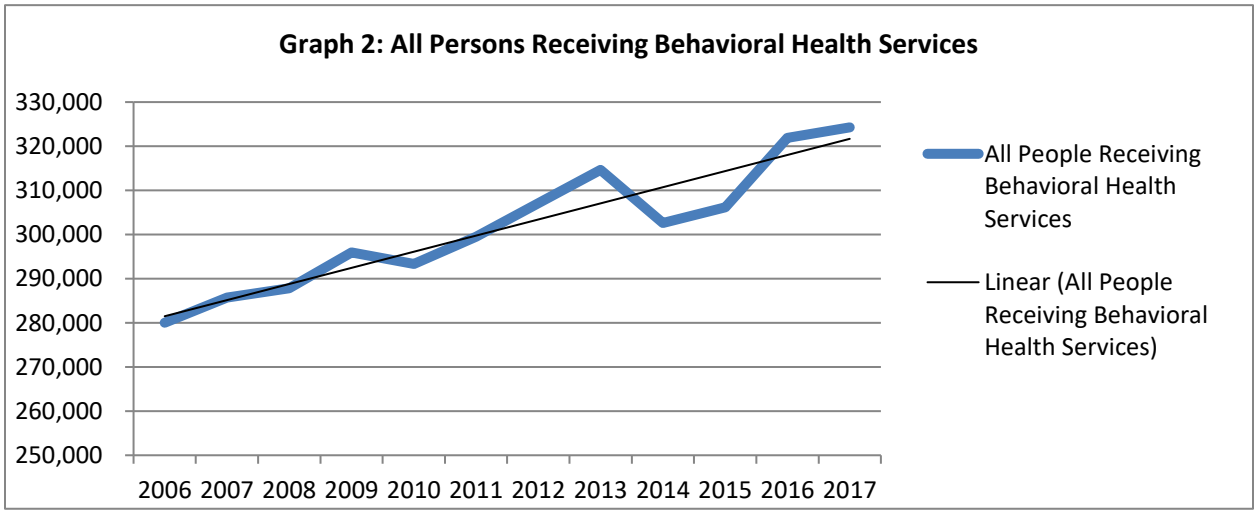
The CMH Association examined the factors that came together in this period (2014 to the present) that have caused statewide fiscal stress, and those have caused this stress to be experienced differentially across the state. Those factors are outlined below.

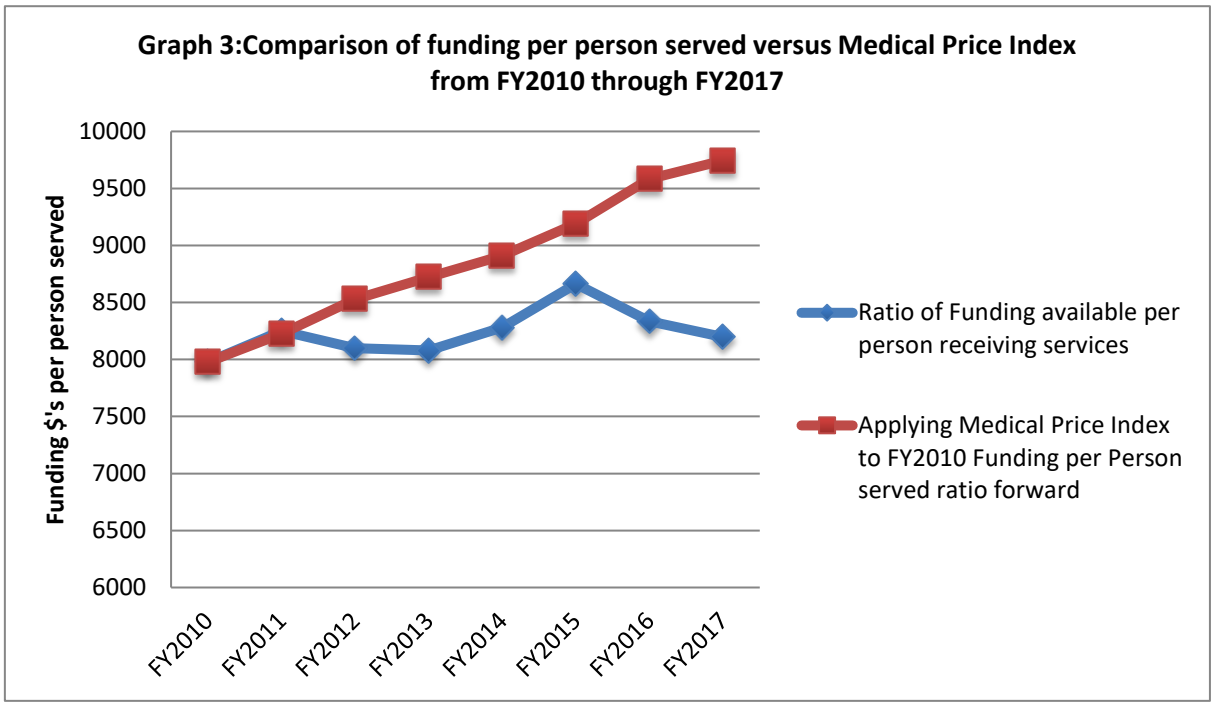
Causes of statewide fiscal stress – 2014 to the present

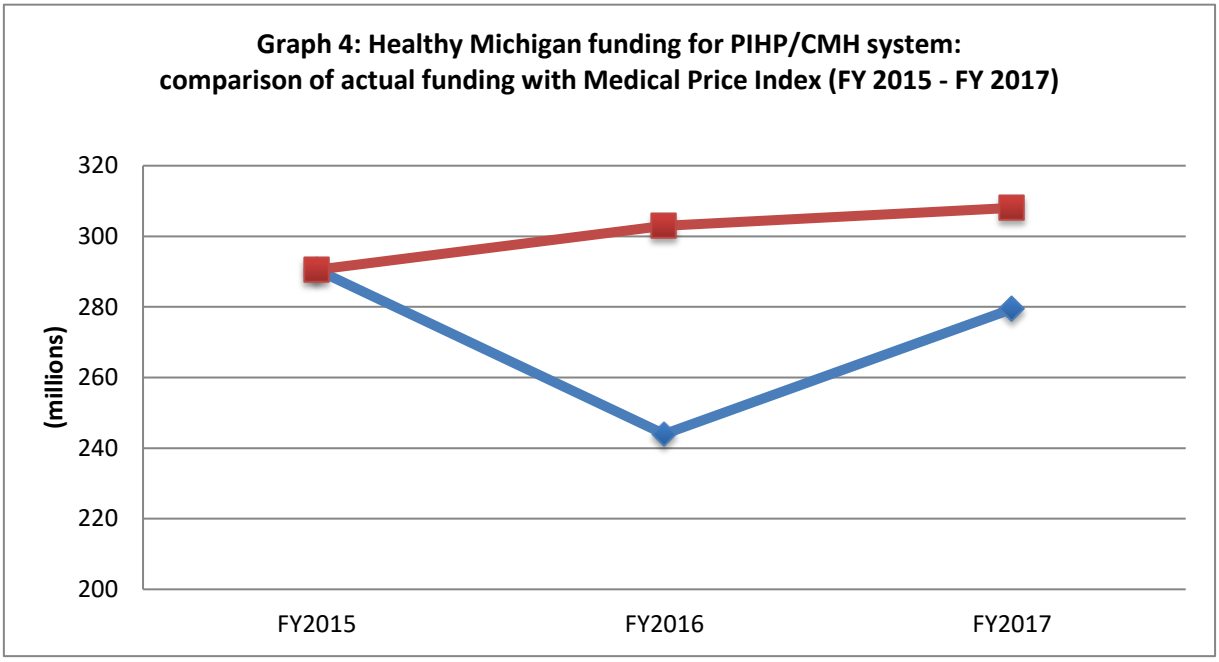
1. State funding to public mental health system not keeping pace with increased demand and health care cost increases, from FY 2014 to the present: The funding to Michigan's public mental health system started to lag in FY 2014 and has increase since that time (**See Graph 1**),



While the **number of persons served by Michigan's public mental health system continued to climb** (**See Graph 2**), this gap in funding, led to dramatic drops in the public dollars available, per person served, to meet the mental health needs of Michiganders. (**See Graph 3**)







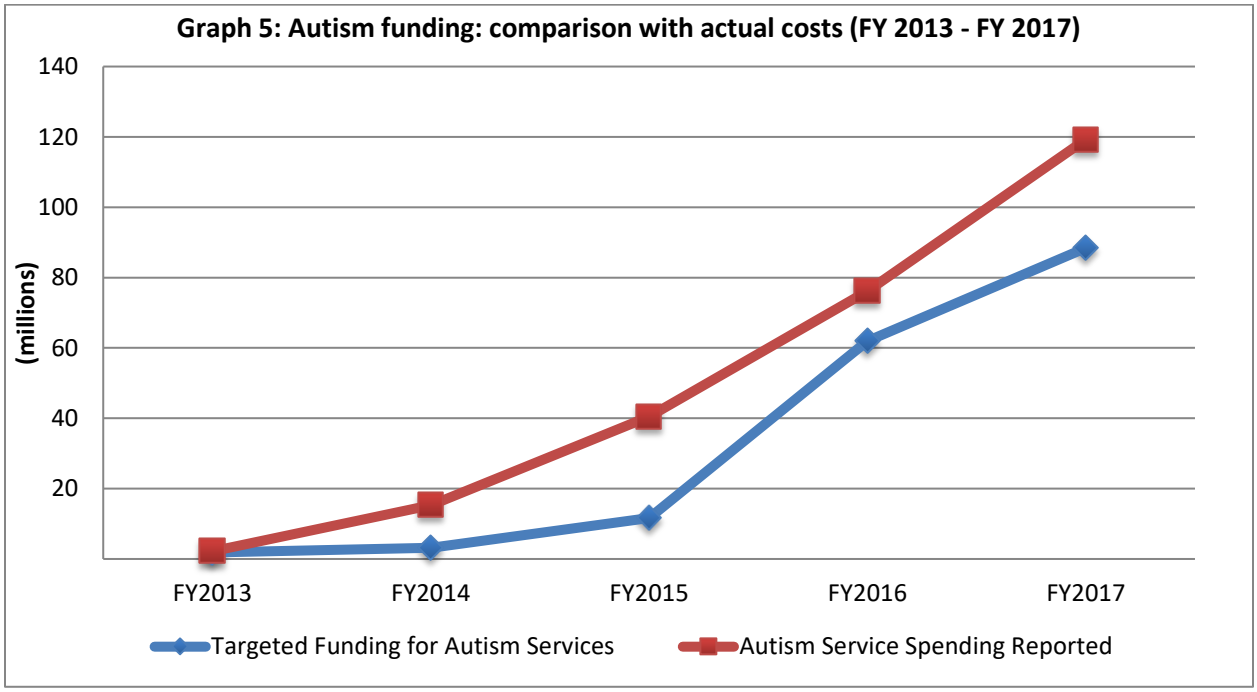
Additionally, the Healthy Michigan Plan (HMP) Introduced in 2014 with a lag in demand; penetration and intensity of needed care are now strong. As a result of the slow uptake by HMP enrollees, the **HMP rates were dramatically cut in FY 2016 (over 20% cut) at the time that substantial demand for HMP was being experienced by the system and have not been restored leaving a sizeable revenue gap (See Graph 4)**. The intensity of treatment needed by HMP enrollees is far greater than initially projected causing the current rates to be far below the funds necessary to meet these needs.

2. Deep cut of $200 million (representing a 60% cut) in General Fund support eliminated a key part of CMH fiscal infrastructure: As part of the implementation of Healthy Michigan, in FY 2014 and 2015, 60% of the state's General Fund support for the CMH system was eliminated ($200 million). These General Fund dollars were part of the fiscal infrastructure of the CMH system, used to serve persons without Medicaid and to buffer against Medicaid demand and cost fluctuations. This loss of these dollars, 8% of the system's entire revenues – greater, in fact, than the risk reserves allowed to be held by the PIHPs – left the system without one of the key components of its fiscal infrastructure.

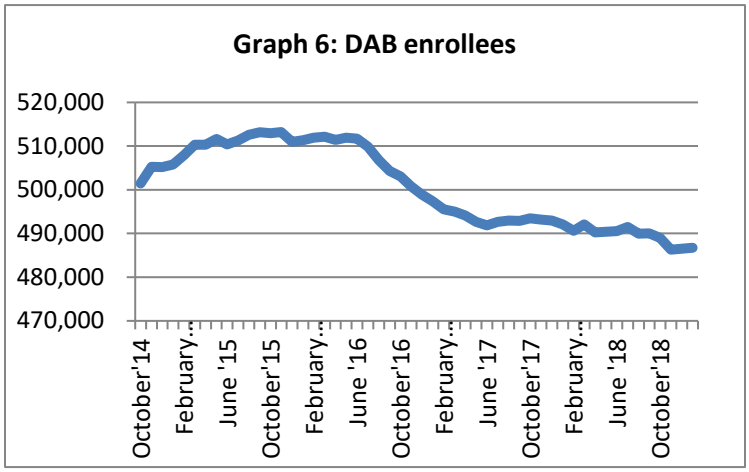
3. Increased demand for substance use disorder services, especially opioid treatment: In 2015, the state's PIHPs also took on the role as the public manager of the state's substance use disorder service delivery system. Taking this role coincided with dramatic increases in demand for substance use disorder services, especially opioid use disorder treatment.

Additionally, the influx of federal State Targeted Response (STR) and State Opioid Response (SOR) dollars, aimed at increasing outreach to persons with opioid use disorders, awareness of the need for treatment, and the provision of treatment-related supports (training of practitioners on evidence-based practices, recovery housing, peer recovery coaches) served to dramatically increase the demand, on the public system, for opioid treatment – medication assisted treatment (MAT) and therapy – **increases demand for opioid treatment but without adding dollars to the treatment system to meet this increased demand.**

4. Dramatically expanding autism benefit without matching revenues: Michigan's Medicaid autism benefit was Introduced during this period, initially limited to children ages 0 through 6, with the age range greatly expanded, to age 21, soon after the benefit's introduction. The downward pressure on appropriations and actuarial rates has caused revenues to be far below the revenues needed to meet demand. (**See Graph 5**.)

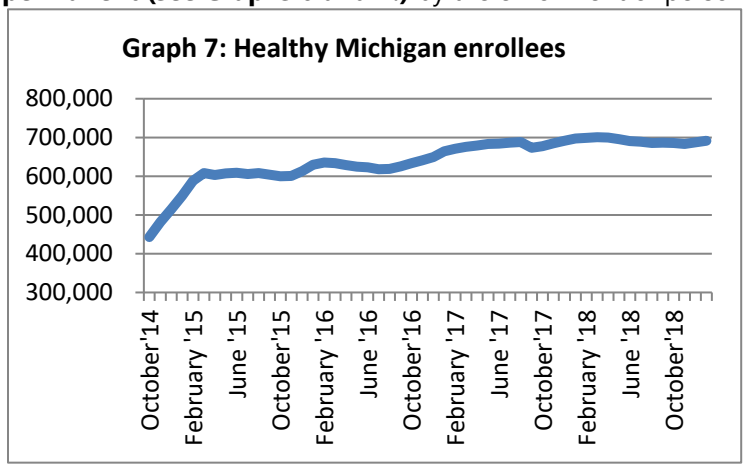


5. Revenue loss (an 80% cut in per enrollee revenues) due to high cost traditional Medicaid enrollees moving to low revenue Healthy Michigan Plan: The introduction of the Healthy Michigan Plan (HMP) saw a large and unprecedented number of persons with Disabled, Aged, and Blind (DAB) Medicaid status leave this program and move to the Healthy Michigan Program.

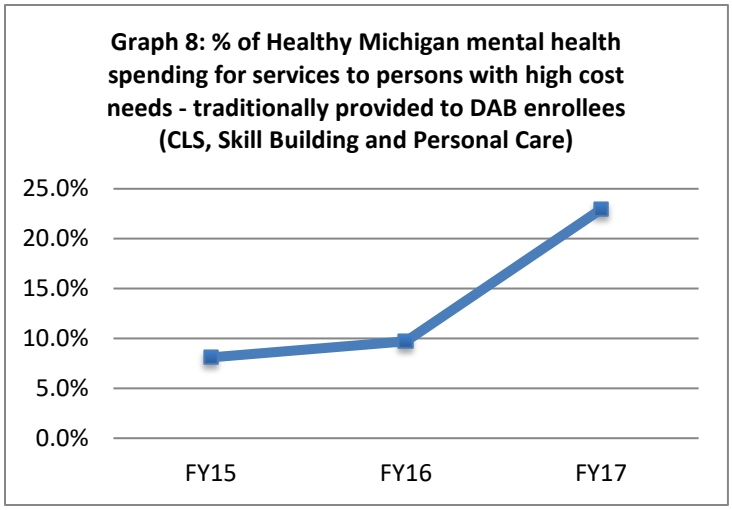


This movement of Medicaid enrollees to Healthy Michigan, starting in early 2016, caused, and continues to cause, a deep revenue hole for the PIHP and CMH system given that **revenue received by the CMHs/PIHPs for these enrollees dropped by 80% when they moved from traditional Medicaid to the Healthy Michigan Plan**. This revenue reduction is due to the fact that the Medicaid DAB rate is designed to meet the high cost services needed by these enrollees, while the Healthy Michigan Plan is a program designed for persons with much lower cost needs. This 80% cut in this large segment of the CMH/PIHP budget leaves the CMH/PIHP system with a substantial fiscal hole.

The sustained low enrollment in DAB and movement to HMP continues and is being made permanent (see Graphs 6 and 7.) by the enrollment of persons who would formerly have enrolled in DAB status, enrolling, directly, into HMP.



This movement, to HMP, designed, with revenues to match, for persons with mild to moderate mental health needs, of persons with much higher cost needs, those that should be served through obtaining DAB status, with much higher revenues, underscored, in **Graph 8**. This analysis show the **dramatic growth in the provision of high cost services to the HMP population** (now making up 22% of all HMP expenditures) – services traditionally received by DAB enrollees (Community Living Supports (CLS), Personal Care, and Skill Building services) – without changes in the HMP payments to the CMHs/PIHPs to match these much higher costs.



The migration of DAB to HMP, by these enrollees (for good reasons – ease of gaining and retaining Medicaid/HMP eligibility and the elimination of spend down requirements - is not the problem. The problem is that the rates paid the CMHs/PIHPs for the Medicaid program to which they are enrolling, HMP, need to be increased to cover the much higher costs of these persons who would normally be DAB enrollees.

6. 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.

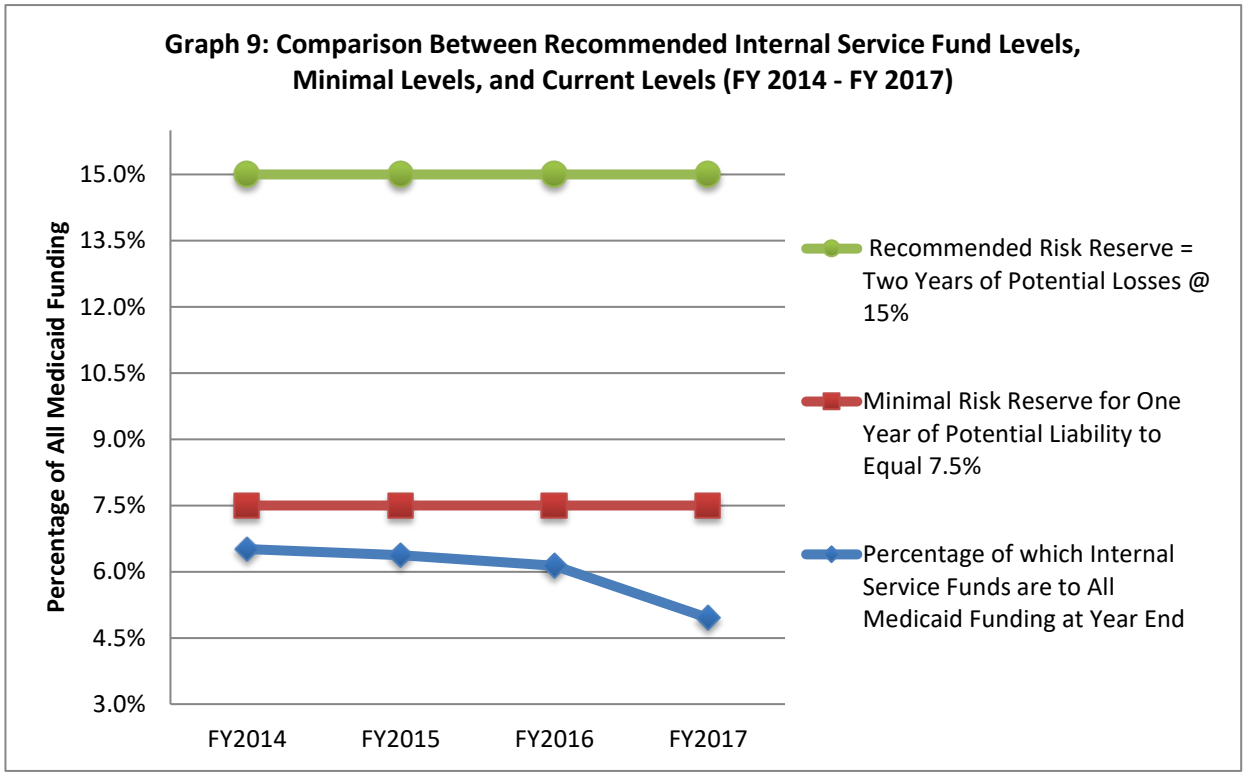
This lack of appropriate financing has harmed the ability of the state's public mental health system to build and hold reserves sufficient to ensure that they could withstand the fiscal risk inherent in a managed care system – fiscal risk exacerbated by the insufficient benefit component of the rates.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

This lack of federally mandated risk reserve contributions, when combined with the insufficient rates have left the public PIHP system with anemic risk reserves (**See Graph 9)**



7. Inappropriate state demand that local funds be used to close Medicaid funding gap: Local funds, those revenues received by the CMH system that do not come from state nor federal sources, are inappropriately drained from the system to cover state Medicaid obligations. 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.

Causes of differential/uneven impact of fiscal distress across the state - 2014 to the present

1. Widely disparate impact of FY 2016 and FY 2018 Medicaid ratesetting: The Medicaid rate setting process (often termed, rebasing), implemented over the last several years caused dramatic and widely varying swings in Medicaid funding. During this period, the **cumulative changes in rates ranged from PIHP revenue cuts of 8.5% to increases of 20%** - at a time during which demand for services continued to grow. Acute and widely varying revenue swings of this magnitude, implemented in a very timeframe, caused dramatic differences in the fiscal health or stress of the state's PIHPs and their CMH members.

It is key to recognize that **the revenue increases received by the appropriately funded PIHPs are not the problem**. The revenue increases to the state's PIHPs, even those that are appropriately funded, in fact were very small, given the dramatic growth in the HMP population over this period. The problem lies in the lack of revenue increases provided to the system as a whole and especially **acute for those with the lowest revenue gains or revenue reductions over the past four years.**

As a result, those regions without sufficient revenue increases or with revenue losses, over this period, **are short tens of millions of dollars every year for the past several years** – thus leading to the fiscal instability of the PIHPs in these regions.

2. Dramatic differences in demand for services not matched by funding: The demand for Medicaid mental health services and the intensity of the needed services are not uniform across the state. These demand differences for all services, most notably autism, HMP, intellectual and developmental disabilities, and opioid treatment services, cause dramatic differences in the expenses incurred by the CMHs and PIHPs across the state.

3. Insufficient number of higher-revenue Habilitative Support Waiver slots to meet high-cost needs: A program within Michigan's Medicaid system, the Habilitative Support Waiver, provides increased funding to the state's PIHPs to serve persons with intellectual and developmental disabilities with complex and high cost needs. This funding is provided through the use of a finite number of HSW slots to the state's PIHPs. The funding for these "slots" is over 10-times the funding provided to the PIHP system for a typical Medicaid enrollee with intellectual and developmental disabilities. A CMH/PIHP without access to these waiver slots must provide the same level of services to the Medicaid enrollees with high cost needs, but with 1/10 of the revenue for that enrollee. While variation in demand and need is expected, as noted above, **the current limit on the number of Habilitative Support Waiver slots causes some PIHPs to have a sufficient number of these slots while others receive far fewer slots than their community needs.**

The lack of Hab Waiver slots is clearly seen when the **57.6 Hab Waiver Slots are available, per 10,000 Medicaid enrollees**, in some parts of the state (a sound ratio, reflecting real need) while **16.8 Hab Waiver slots are available, per 10,000 Medicaid enrollees**, in other parts of the state.

As with the Medicaid revenue discussion above, it is key to recognize that **the number of waiver slots awarded to the PIHPs with the higher waiver slot ratios is not the problem**. The number of waiver slots, even in the communities with higher ratios of waiver slots, are insufficient to fund the needs of persons in those communities. The **problem lies in the lack of Hab Waiver slots** provided to the system as a whole and especially acute for those with the lowest Hab waiver slot ratios.

The Center for Healthcare Integration and Innovation (CHI²) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing the state's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.